West Berkshire Council

Birchwood

Inspection report

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Date of inspection visit:
31 May 2018
04 June 2018

Date of publication:
21 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was completed on 31st May and 4th June 2018, and was unannounced on the first day. Birchwood is a 60 bed service that provides facilities over three floors to older adults with varying needs. The ground floor provides a respite service for up to ten people undergoing an assessment period when transitioning from hospital or home and prior to an appropriate care package being sought. The first floor provides residential services to a maximum of 25 people. The second floor provides nursing care to a maximum of 25 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. People's needs varied depending on their diagnosis. We found some people required extensive support whilst others were able to complete some tasks independently.

This inspection was carried out to establish if improvements to meet legal requirements planned by the provider after our October 2017 inspection had been completed. The team inspected the service against all five key areas. This is because the service was not meeting legal requirements and was rated overall as inadequate and placed in special measures. At our last inspection, we found the provider was in breach of nine regulations. Following that inspection, on 22 August 2017, the provider sent an action plan which identified improvements to ensure the service was no longer in breach of the regulations.
At the inspection of October 2017, the provider was rated overall inadequate, with three ratings of inadequate in 'Safe, 'Responsive and 'Well-led. 'Effective' and 'Caring' were all rated as requiring improvement. At this inspection we found the provider's had made improvements in all inadequate domains. As a result the overall rating of the service has now been changed to requires improvement. The changes to the key lines of enquiry have meant that additional information is sought in some of the domains.

The service had appointed and registered a new manager in January 2018. However, due to unforeseen circumstances the registered manager had been absent from the service for a period of two months, but had returned to work prior to the inspection. The service was managed by an interim deputy manager, with the additional support of the local authority services manager. However, the management overview remained inconsistent during the period of the registered manager's absence. 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.

People were not always kept safe. Whilst risk assessments were in place for people, these did not provide information to staff on how to minimise the possibility of a risk. This meant that staff did not always know how to manage a risk should one arise . The provider did not have robust systems in place to ensure sufficient suitably qualified or safe staff were employed to work with people. A criminal records check and photographic identification was missing from staff files and there were gaps in people's recorded

employment history. Of the nine files reviewed all had information missing.

Medicines were not always managed safely, putting people at risk. Covert medicines did not have appropriate directions in place, or evidence of best interest decisions to illustrate how this decision had been reached.

People received care and support from staff who had completed the provider's identified mandatory training, skills and knowledge to care for them. . The provider had a comprehensive induction process in place that involved both the corporate and location induction.

Staff were appropriately supervised in their role to carry out their duties both safely and effectively. However staff were not always deployed in the most appropriate way to ensure that the experience of people was as they would hope to receive within a timely way.

We were told staff were caring, and ensured people's dignity was preserved at all times during personal care. However, the language and approach of staff was not always respectful. We found that during mealtimes and when discussing people, the language and approach of staff was not always dignified. During all our observations staff rushed people, offering a task based service, rather than one which was person centred.

The service was not always well-led. Whilst the provider had systems in place to monitor the service, these were not always adequate. The systems in place did not fully maintain an overview of the service. The registered manager was reliant on the provider authorising many of the requirements of the service. The lack of a timely response in responding to many of these requests worked against the service and the registered manager.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Comprehensive recruitment checks had not been completed to ensure staff were safe to work with people. Care plans although in place, did not contain sufficient information on person centred care. The staff practice further was not always person centred, with language used lacking respect and dignity. Audits although in place, did not fully gather information to ensure the service was delivering care in line with legislation and the fundamental standards. The fundamental standards are regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Risks were not appropriately assessed. Staff were not provided with guidance on what actions to take if the risk arose.

Covert medicines were not appropriately managed by staff, and medicines were not stored safely upon delivery .

Recruitment procedures did not ensure staff were safe to work with people.

Incidents and accidents were appropriately assessed to mitigate similar occurrences.

Staff had a comprehensive understanding of safeguarding and whistleblowing procedures.

Staff had a comprehensive understanding of safeguarding and whistleblowing procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not deployed and working effectively to support people.

Staff received an induction which included all mandatory training and shadowing of staff.

Staff had a thorough understanding of the Mental Capacity Act, and ensured that people's consent was sought when assisting them.

Staff were appropriately supported and supervised.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always speak about and treat people in a dignified

way.

Staff were reported by people to be kind and compassionate.

People and their families were involved in making decisions related to their care and where applicable reviews.

Records were stored securely ensuring confidentiality was maintained at all times.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although people had their needs assessed, these were not always addressed in a person centred way.

We saw evidence of complaints being appropriately investigated. People reported that they knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits completed monthly did not illustrate areas where changes were needed to care plan paperwork.

The registered provider did not provide effective support to the registered manager.

There was a strong ethos for the service that the management team wished to embed into their care delivery.

Quality assurance surveys had been completed. Action plans were to be generated.

The registered manager offered an open door policy for both staff and people. They encouraged open communication and welcomed feedback.

Birchwood

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. As part of this inspection we checked that the provider had met the actions of their reports that were sent to us monthly in response to our last inspection.

This inspection took place on 31 May and 4 June 2018 and was unannounced on the first day. The inspection was completed by two inspectors and a specialist dementia nurse advisor. Additional supporting evidence was provided following the inspection by the provider, for us to review.

As part of the inspection process the local authority were contacted to obtain feedback in relation to the service. We referred to previous inspection reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, which they are required to tell us about by law. As part of the inspection process we also look at the Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make, in relation to the five domains we inspect. We had not requested the PIR for Birchwood; therefore this was not available for us to review. As the location was rated inadequate at the last inspection the provider had submitted monthly reports to illustrate any improvements they had made and were planning to action. We used these reports to help plan our inspection.

During the inspection we spoke with 12 members of staff, including the registered manager, the clinical lead, deputy manager, three registered general nurses, the residential care officer, a domestic and four dementia practitioners. We further asked five staff to complete a short survey on the service. We spoke with two people who use the service and three relatives of people who were authorised to speak with us on their behalf. In addition we spoke with five professionals. We employed the Short observational Framework for Inspection (SOFI) over lunchtime on both days of the inspection. The SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We further made general observations throughout both days of the inspection, including medicine rounds.

Records related to people's support were seen for ten people who use the service. In addition, we looked at a sample of records relating to the management of the service. For example staff records, complaints, quality assurance assessments, policies and procedures. Staff recruitment and supervision records for nine of the most recently recruited staff, including the clinical lead were reviewed as part of the inspection process.

Requires Improvement

Is the service safe?

Our findings

At our inspection of October 2017, the service was rated inadequate in the 'Safe' domain. The service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which says that the care and treatment of people must be provided in a safe way. The service did not adhere to this regulation. Risks were not appropriately assessed, the service was not sufficiently clean which posed a potential risk of infection. Risks associated with medicine management were not considered or addressed. We found at this inspection whilst some improvements had been made, some issues remained. The provider remained in breach of this Regulation.

People had risk assessments in place that were reviewed on a monthly basis or as required. However, there was insufficient information in these to illustrate how to manage the risk should it arise. For example, one person's risk assessment stated the person was at risk of falls. Details on how to mitigate the risk were included within the risk assessment; however what action staff needed to take should the person fall was not included. Another person had a risk assessment that scored them at high risk of falls. No further information, including possible measures was provided within this or any other document on how to mitigate and manage the risk for this person. This was similar for a person who was at risk of choking. Staff were not provided with details of what action they needed to take should the person begin to choke, although the care plan did document how to minimise the risk of choking. Staff we spoke with said they would seek assistance from the nurse on shift. This illustrated that staff were not fully aware of what measures they could implement immediately to keep the person safe when choking. The reviews of risk assessments had not picked up that information relevant to keeping people safe had been missed. For some people, risks had not been assessed, to which the care plan referred. For example, one person was described in the care plan as "highly anxious and agitated". No risk assessment was on file to address this element of risk, which could include physically aggressive behaviours, if the person became highly anxious. This meant that whilst the person was being supported by staff they did not have the necessary information on how to keep themselves or the person safe when the person became agitated and anxious. This risk was further increased by the number of agency staff employed who did not know the resident well, therefore may not be fully aware of how to keep the person safe. Staff told us that the person had become highly agitated and anxious at times. We also observed this during the inspection. We noted that staff's approach was inconsistent which potentially led to the person becoming more agitated.

On both day one and two of the inspection we observed a medicine round. Medicines were kept securely in a medicine trolley that was stored in a temperature controlled medicine room per floor. On the ground and second floors of the service the registered nurse (RGN) was responsible for administering all medicines. On the first floor this was the responsibility of the senior registered care officer (SRCO). At our last inspection we had concerns about how medicines were administered. At this inspection our observations illustrated that medicines were generally administered safely. The RGN and SRCO were cross referencing these against the medication administration record (MAR sheet). They checked doses, names of medicines and quantities before administering. These were generally administered in the way the person wished in accordance with their care plan. However, for one person on the first floor we found that the SRCO had administered multiple tablets in a medicine cup to the person, tipping these in their mouth and then giving them water. The

person, who had multiple health complications, was seated in a specialist chair with their head resting on the head rest. We found conflicting information in this person's care plan. The care plan detailed that the person preferred to take their medicines by spoon with juice. The SRCO who administered the medicine sat with the person, speaking to them gently, smiling until they had reassured themselves that the medicine was swallowed. The interaction and engagement was positive however it was unclear if the person now preferred to take their medicine in this manner.

In another example, we found that one person who was prescribed a swallowing aid, that was to be administered daily, had this given to them intermittently. The daily recording sheet was kept in the person's daily records folder and not with the MARs as this was given by dementia practitioners. It was not possible to determine if the error was one of recording, or one of missing doses. By failing to appropriately provide the person with the swallowing aid, the staff had put the person at risk of choking.

During the inspection we case tracked five people who were on covert medicines. These are medicines that are given to people in a disguised form. A person who is on covert medicines, needs to have a mental capacity assessment completed, illustrating they lack capacity to make an informed choice. This needs to be done for each medication. A best interest decision then needs to be made by a qualified health professional (e.g. a doctor) in consultation with family and / or staff. The service then needs an expert (e.g. a pharmacist) to state how the medicine can be safely administered (e.g. in yoghurt, with juice etc.) We found that for all five people on covert medicines none had evidence of completed best interest decisions in either their care file or within the medicine folder. Further the care plans did not evidence how the medicines needed to be administered safely. This meant that people were put at potential risk of receiving their covert medicines both inconsistently and potentially in a non-agreed manner. The management acknowledged that this was an area where further development was required. We were shown a document that evidenced this point had been picked up in an audit earlier in the month, however no action had been taken to resolve the issue by the time of the inspection.

During our first day of inspection we saw the service had received their delivery of medicines for the next month cycle five days in advance. This was stored in the clinical lead's office. The room was noticeably warm, and no measures had been employed to record the temperature or maintain the room at a suitable temperature. The current national guidance states that medicines should be stored below 25ºC. Where medicines need to be stored within a refrigerator, the temperature should not fall below 2ºC and above 8ºC. We spoke with the clinical lead, who confirmed the room was warm and that no records were taken of the temperature to ensure medicines were stored correctly. If medicines are not stored at the correct temperature they may not work properly. By failing to monitor the temperature the service were unable to confirm the medicine would be effective and safe to use.

We noted that the room was accessible to RGNs, and sought confirmation that the medicines had been checked in. The clinical lead advised that the only medicines that were checked in at point of delivery were the controlled drugs. These were then securely stored in the relevant medicine rooms per floor. We queried how the service could reassure themselves they would have sufficient amounts of medicines on the day the new medicines commenced (Monday). We were told that they could not. On the second day of the inspection, we observed staff calling the pharmacy and requesting missing medication. By failing to check the medicines in, the service had not ensured the correct amount of medicine was available. The service remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the service was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not fully understand its duties to safeguard or

appropriately investigate abuse. At this inspection we found that staff had a comprehensive understanding of what was abuse, and ensured this was reported appropriately. The service had developed systems and processes to reduce the risk of abuse. Where required, the registered manager liaised with other professionals and completed a thorough investigation to help prevent similar occurrences. The service was no longer in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection of October 2017, the service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service did not appropriately deploy staff to be able to carry out their duties safely and effectively. At this inspection we found some issues remained present, however as significant steps were taken the service was no longer in breach.

It was evident sufficient staff were employed to provide effective care for people. However, the deployment of staff meant peoples' experience during mealtimes was neither enjoyable nor promoting of good eating. We spoke with the registered manager regarding this issue, and were advised that the lack of Residential Care Officer's across the first and second floor meant that shifts were not appropriately planned. This was acknowledged as leading to people not receiving effective care during mealtimes in particular.

People and their families told us staff sought consent before completing personal care, although they remained task focused, as per our last inspection of October 2017. One relative said, "The girls are very good, but a little quick at times." A person we spoke with said, "They do ask me, at times I just agree because I know they are very busy." We noted sufficient staff were employed on each floor to offer assistance to people. This issue appeared to be linked with staff deployment, and a staff perspective of having to complete personal care by a specific time, although no time limits had been stated by the registered manager.

People were not kept safe by the provider's current recruitment processes. The registered person did not operate effective and robust recruitment and selection procedures to ensure they employed suitable staff. We reviewed the files of nine staff who recently started working at the service and all the files had some information missing. Eight files did not have proof of identity including a recent photo. Gaps in employment were not verified or checked, including reasons for employment termination. The passport of one staff who transferred from another of the provider's services, expired almost four years ago, but was still used as identification. Five staff did not have a date of their Disclosure and Barring Service check(DBS) in the file. Four staff were not DBS checked. A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. We received written confirmation from the provider's human resources department that staff who did not provide personal care did not require a DBS in accordance with the provider's policy irrespective of them, lone working with people in some situations where they may require assisting with personal care. One staff who has a professional qualification verified by use of a PIN number, did not have this documented within their file, irrespective of them carrying out the duties in accordance to their qualification. The provider did not adhere to their policy of safe recruitment.

Four staff did not have health information to confirm they were fit for their role. We received only two certificates regarding staff's fitness. We received a confirmation from HR assistant that other two staff had medical clearance and did not need any reasonable adjustments to carry out their role.

The provider's recruitment practices meant people were at risk of having staff providing their care who may not be suitable to do so. This was a breach of Regulation 19 and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not established and followed recruitment

procedures to ensure the suitability of staff employed.

The service recorded and monitored incidents and accidents. This meant the service was able to note trends that may be present in order to reduce the risk of similar occurrences in the future. This was an improvement on the last inspection where we found that no analysis of such events.

The provider had a business contingency plan in place detailing what action the needed to be taken in the event of foreseeable emergencies. Examples included adverse weather conditions as well as staff shortage due to illness. Emergency contact numbers were included within the contingency plan, as well as what staff should do if any issues arose at the premises.

People and their relatives told us they felt safe with the staff who supported them. We were told, "I feel safe with the staff here, they are good to me." Another person said, "Oh very safe. They are lovely." The registered manager completed a daily walk around of each floor speaking with people and any visiting relatives. We were told, "The registered manager walks around too, staff are good and look after people well."

At the time of the inspection we found that the service was generally clean. Equipment, bedrooms and communal areas were tidy, although a little tired. However, carpets predominantly on the first floor remained sticky with a noticeable pungent odour when first entering the floor. We witnessed the domestic staff continually cleaning the areas over both days of the inspection. We asked about the smell and the carpets, and were told by staff that only areas where fluids had fallen or the carpet was dirty were cleaned. We spoke with the registered manager regarding the smell and the carpets, querying whether they had considered possible infection control methods linked specifically to possible germs associated with the carpets. The registered manager acknowledged the issue. The provider however, advised that a deep clean was scheduled for after the refurbishment had been completed. We raised concerns about this, especially as the works were scheduled to continue for a further four months. We were subsequently advised by the registered manager that a deep clean had been requested as a matter of urgency.
We recommend that the provider considers methods of staff deployment that utilise staff, and ensures that care provided to people is both safe and reflective of their needs.

Requires Improvement

Is the service effective?

Our findings

At the inspection of October 2017, we found people were supported by a staff team that had not received effective training to help support them within their role. Staff did not have the correct training to keep people safe from risk. For example, people were being supported who had epilepsy, required catheter care and had dementia, by staff who did not have the necessary training in these areas, to support them. A comprehensive training record was provided post inspection of all training that had been arranged for staff. The service was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, specifically when considering the training and support offered by the provider. At this inspection we found that some staff had received the required training, whilst others were planned to receive the training by the end of 2018, although they had not been booked on the courses. Significant steps had been taken by the management to ensure the service was no longer in breach. The provider had arranged the dementia bus in early 2018. The dementia bus is a virtual training course that simulates experiences of dementia to trainees. Its aim is to challenge trainees perception of people living with dementia, and understand how their practice may affect the person further. Alternative and more successful methods of working are discussed as part of the course. Some staff from Birchwood had attended the course. As not all staff were able to attend, the dementia bus was rearranged twice so that as many staff as possible would be enabled to attend. In addition, the provider had commissioned a dementia course specifically catering to the needs of the people within the service. This was scheduled to be delivered in September 2018, and would look at how staff should support the people living there.

At the last inspection we found staff had not received any formal supervision or support from the provider or the registered manager since the local authority had taken operational control of the service. At this inspection staff told us, "We receive supervision regularly. It's a good chance for us to discuss things with our line manager." We saw a supervision programme had been devised by the registered manager. The senior management team, consisting of the registered manager, deputy manager and clinical lead all took responsibility for supervising specific staff. The registered manager retained an overview of supervisions, ensuring these took place and audited them to ensure any raised issues were appropriately resolved.

There was a corporate induction in place that focused on working for the local authority. This was reinforced with an induction at location level that included job and site-specific details. All new staff received mandatory training that was in line with best practice guidance. Staff were required to complete the modules of the care certificate within 12 weeks of commencing employment. The care certificate is an identified set of standards that forms part of the good practice framework. It consists of 15 modules that all staff should have knowledge in when working in social care. We saw evidence that new staff had been enrolled on the required mandatory courses, and had received the induction. Staff reported, "The induction is detailed. It tells us what to expect when working for the local authority as well as information about the service."

At the last inspection we found care plans did not contain sufficient information on how to support people with their nutrition and hydration needs and most other aspects where needs were to be assessed. At this inspection we found improvements had been made. Care plans identified when people needed support

with eating and drinking. These were reviewed as required according to staff signatures. Staff recorded details of how much people had eaten and drunk on specific documentation where this information was required. However, we found that nothing appeared to be done with this information. For example, we case tracked one person, whose relative approached us and raised concerns regarding insufficient support being provided to assist the person in this area. We looked at these records for the last five weeks and cross referenced them. We found the person was being weighed as required monthly, and appeared to be steadily gaining weight. However, the food charts and hydration records indicated that the person was neither eating sufficiently nor drinking the target 1200ml of fluid daily. We found that over a four day period the person was recorded as having only eaten a sandwich, declining all other meals and snacks. The average fluid intake recorded for the person was approx. 650ml per day, almost half of the required amount. The person's relative spoke with us and raised a concern that the person was not supported adequately to eat or drink.

We spoke with the staff regarding the level of support offered to the person, and were told that offering assistance during mealtimes was not part of the person's agreed package. Staff would ask the person if they wanted the food available, and if the person declined this response was accepted and recorded. We cross referenced the daily records and found that this was the general pattern over the last month. The care plan indicated that staff were to support the person with food and drink, noting they would often decline meals. However what level of support should be offered was not documented. Further the fact that the person was steadily gaining weight, whilst consuming insufficient amounts of food and drink had not been picked up by staff. This had not been discussed with any health professionals involved in the care of the person. We spoke with the registered manager regarding this, and established that they were unaware of the potential concerns related to the person receiving effective care. They acknowledged that this was an area of concern, and assured us that this person's file would be reviewed as a matter of priority.

We observed during our inspection that people on the ground floor received appropriate support with their meals. People were given time to eat, choosing to eat in their room, dining room or the lounge. They were supported as required and given an opportunity to request seconds should they want this. People were complimentary about the food. One person said, "The food is lovely, and the amount is good too!" However, we noted that on both the first and second floors the support was different. People did not always get appropriate support or support that was reflected their preferences.

We observed one person had fallen asleep during lunch. They had eaten two to three mouthfuls of food only. They were sat alone in the lounge. A member of staff noted we were sat in the lounge and entered, noticing the person asleep. They woke the person and asked if they were okay. The person, agitated at being woken, responded, "Go away." They were asked if they wanted their food and said no. The member of staff took the plate away and then returned with two options for the pudding. The person was highly agitated now, and responded harshly to the staff making it clear they did not want anything to eat. We were told this was what the person would usually do. They decline the food, and became agitated. We queried whether alternatives were offered or the mealtimes varied for the person, and were told no. They were offered options at the mealtime, and may be offered sandwiches if they said they were hungry later, however mealtimes are set. Similar observations were made across both floors in dining rooms and in communal lounges over both days. We noted immediately after meals were finished staff would commence writing in daily records. On one floor five of the six staff were observed in the lounge updating documentation immediately after lunch, leaving one staff working across the floor looking after a maximum of 25 people. This was raised to the attention of management who advised they would discuss this with staff during staff meetings.

People were cared for by a staff team that had a clear understanding of the principles of the Mental Capacity

Act 2005 (MCA). All staff employed had received training in the MCA, as this was perceived as mandatory training. 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. We found that DoLS applications had been requested as required by the registered manager.

People told us they were able to see the visiting GP and other health professionals as and when required. They told us the staff ensured they could access healthcare and support appropriately. We spoke with two visiting health professionals who commended the staff and in particular, the clinical lead. We were told, "The staff are excellent, if a person becomes unwell, or needs some support, they contact us immediately." Another health professional stated, "[clinical lead] is an asset to the service. She is very good. She knows peoples' needs and responds to them very well and effectively." Contact sheets illustrated that specialist health professionals were consulted as required. These contact sheets continued to be updated with relevant information, although the service had experienced issues with some professionals refusing to complete them..

The service had developed a refurbishment programme following our last inspection that highlighted the premises were not dementia friendly. The provider had commissioned a dementia architect that was looking at each of the floors and considered what alterations could be made to the premises to make these more appropriate to people who were living with dementia. This included changing the colours of the walls in all communal areas, changing the lighting, changing the flooring and all soft furnishings. We noted the schedule for the refurbishment had commenced with work being undertaken on the second floor first. People, their relatives and staff were all looking forward to the changes the provider was making to the premises, believing this would have a positive impact on people's wellbeing.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found that the service required improvement in the area of caring. At this inspection we observed some caring interactions between staff and residents. Staff spoke with people gently and calmly. They were polite, smiled and appropriately used touch to get people's attention. However, we also observed staff being 'task focused' which did not demonstrate a caring response, specifically during mealtimes.

Staff were able to correctly describe to us how they would preserve people's dignity when assisting them with personal care. People reiterated this point, advising that staff would knock or call out to the person before entering the room, and explained what task they were going to complete. Most people and their relatives told us that staff would check that the person was okay with this before proceeding. We saw evidence of this in several daily records, where staff had recorded that a person had declined personal care. A subsequent recording illustrated that staff had returned and asked the person again if they wished to have personal care. When personal care was being delivered, the door was closed, and where appropriate, curtains drawn and the person covered. People we spoke with confirmed that staff did take the necessary steps to maintain their dignity when delivering personal care.

During our inspection of October 2017, we noted that mealtimes were task focused. This meant the approach was not always caring. At this inspection we observed a similar approach. As previously detailed in this report, observations were completed during both days of the inspection during lunchtimes across each of the floors. On the second floor we focused on four people, three of whom required support with eating. The staff who were assisting offered task focused support. During one observation a member of staff was trying to assist two people with eating at the same time. We observed little or no communication between staff and people across both the first and second floor. People were not asked before being offered a mouthful of food, nor were they asked what they wanted to eat, for example, the vegetables or the meat. We did not observe any social interaction or general chit-chat. In another example, we observed one person being physically assisted to leave the lounge and go to the dining room for their meal. The person repeatedly protested, however staff took the person and seated them in the dining room with other people. It was unclear why they were unable to remain in the lounge. During the lunch period we observed people looked disengaged. We observed that some people sat for the entire lunch period without speaking or interacting with any one. Staff were also observed as not interacting with people, with the exception of offering the next mouthful.

Staff generally spoke to people in a dignified and respectful way. However on two occasions people were referred to by senior management as "the feeders" and "need feeding". This language and terminology is neither dignified nor respectful. We spoke with the senior management team about this at length during the inspection, reinforcing the need to ensure that people are treated with respect and dignity at all times, including when they are being discussed in meetings. This was particularly concerning given that these words were used by the senior management. The language and the lack of engagement during mealtimes meant that people were not always treated with respect and dignity whilst being supported. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,

which stipulates that people must be treated with dignity and respect.

Relatives we spoke with during the course of the inspection predominantly provided positive feedback about the care their relative received. One relative told us that he had seen a, "vast improvement since the last inspection." Another reported, "This place has had some difficult times, but they really are picking things up…" However, one family raised concerns about one member of staff. They referred to the staff member as being "rude" providing details of a couple of recent interactions. We raised this issue with the registered manager, who assured us that she would investigate this further.

Relatives told us communication with the home had improved. They advised that a couple of recent relatives' meetings had been cancelled, however, alternate dates were being arranged. We were told the staff were more approachable and friendly generally, appearing more welcoming towards relatives.

People's right to confidentiality was maintained. Care staff respected people's privacy. We observed staff going to an empty room (e.g. dining room or lounge), office or standing to the side in the corridor. Staff spoke in a low tone when discussing people so that the conversation could not be overheard. At our last inspection we found offices on both the first and second floor were left unlocked, with filing cabinets also unlocked. This potentially raised confidentiality issues. However, at this inspection we found offices were securely closed. Cabinets located in communal lounges that housed people's daily recording books were locked.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of October 2017, we found the service was rated inadequate in this domain. The service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person-centred care. We found the service did not have care plans or documents to assist staff in supporting all the people that received the regulated activity. This meant people were potentially put at risk of not receiving support that was responsive to their needs. At this inspection we found there to be some improvements in this area leading to a rating of 'Requires Improvement', however the breach remained in place.

We found that all people had care plans in place. These appeared to be kept up to date with internal reviews taking place monthly. However, during the inspection we case tracked nine people. This involved looking at care plans, risk assessments, daily records, health records, medication documents and any additional paperwork that may be used by the service to inform the care plan. We found that of the nine files analysed, all nine contained insufficient and out of date information within the care plans. This meant that whilst reviews were being signed off as having been completed, these were not adequate to ensure people were receiving care that was reflective of their needs.

For example, we noted that one person had four UTIs in the last two months. They had been prescribed antibiotics and fluid intake needed to be monitored. However, the care plans had not been amended to include this additional information. These had been signed off as having been reviewed. In another example we found there to be conflicting information on how a person needed to be supported with their medication. The care plan read the person was non-compliant with medicines, therefore needed to receive medicines covertly. The next section detailed that the covert medicines needed to be given with water. This had been signed off as having been reviewed and accurate with "no change" recorded in the review section. The registered manager agreed that this did not indicate a comprehensive review of the care plan had taken place. We were told that she would expect amendments made to the care plan that would illustrate change in the person's health and how this needed to be supported. This raised particular concerns as the service still used a high level of agency staff. Whilst the aim was to use consistent agency staff, the registered manager acknowledged this could not always be guaranteed. The service used both agency registered nurses and care staff. The possibility of a person not receiving responsive care was therefore high given the inaccuracies in the written documentation. We noted that people did receive consistent care and that this was dependent on who was providing support. For example, we observed an agency worker approach a person who often refused food with bread and butter for breakfast. We asked the agency worker if they had been asked if they wanted to eat this and were told "no". They were hoping to encourage the person to eat if they could see the food. We spoke with a regular member of staff and asked them what this person liked to eat for breakfast and were told several different foods, however bread and butter was not on the list. We noted that this information was not recorded in the care plan, but was knowledge only some staff had. Further staff had never approached the person with food. The person declined to eat, becoming verbally aggressive.

During the inspection one visiting professional from the local authority was reviewing people's care plans.

We were told that there had been considerable improvement with documents, however, the professional raised that some care plans were still not to a standard that accurately reflected people's needs. The visiting professional advised that they may assist the service with writing the care plans or components of this, in addition to regularly reviewing these. However, on a daily basis these need to be kept up to date by the service. Another professional reported the "service have made progress with care plans. These are now all in place with reviews taking place." We queried whether they had checked the quality of the reviews and were told, "no". The professional recognised that this may need to be considered as part of the reviewing process.

At this inspection we have found that the service continues to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst care plans were now in place, these did not always accurately reflect people's needs. They did not contain sufficient information for staff detailing how people needed to be supported. People were put at risk of not receiving care that was responsive in meeting their needs.

At the last inspection the service was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that complaints must be investigated and proportionate action must be taken. We had found that the service did not maintain a record of complaints and was unable to evidence any action taken following any raised issues. At this inspection we found the service had improved in this area. A file was maintained that clearly outlined the complaints policy and a comprehensive record of the complaint, investigation, outcome and feedback was recorded. The service ensured all complaints were responded to in a timely way and resolved within 28 working days with a written record being kept securely. We found this target had been reached on all complaints. As a result of the improvements the service was no longer in breach.

People and relatives said they were aware of the complaints procedure, and would not hesitate to use this. They felt confident any issues they would now raise would be investigated, and a resolution found promptly. One relative reported that the service was now transparent and open when managing complaints. The relative stated the registered manager acknowledged where errors had been made and worked with the families in an attempt to resolve issues. They felt this, "openness and transparency," illustrated the service's, "drive to achieving change." We spoke with the registered manager regarding this, who reaffirmed this view. We were told that complaints were seen as a learning process. The aim was to learn from the errors and take necessary action to prevent similar occurrences.

At the last inspection the service had employed an activity co-ordinator who was focused on developing activities for people predominantly within group settings. We found people were often disengaged, asleep in chairs with TVs or radios on sitting around the perimeters of the communal rooms. Since the last inspection the service had employed an additional activities co-ordinator. This member of staff has previously worked with people who live with dementia, and has a strong ethos of community engagement. Relatively new to the post, the co-ordinator was seeking to engage people in community based activities. For example, on day one of the inspection an outing had been arranged with a few gentlemen from the service to attend the local pub for lunch. The activity co-ordinator recognised people would need considerable encouragement and motivation to engage in activities, especially as this was a new concept to those who had lived at the service for several years.

We found people still did not have individual activities scheduled. Details had not been gathered to record what activities people liked or disliked, although some files did indicate "life story work" had commenced. This document allowed the service to gather information about the person's life. This information would be used to help devise activities that the person may enjoy. The activities co-ordinators aimed to gather as much of the information as possible from people and their relatives, using this to draw up individual and

group activities both on site and within the community. However, this process was yet to be completed.

At the time of the inspection no one was receiving end of life care. However, the service had previously supported people in this area. We saw evidence within some people's care plans of information on how they wished to be supported should they become unwell. Some files contained information in this area, whilst others remained blank. Staff said some families found this a difficult topic to discuss. This led to many of the documents remaining incomplete. However, the service had a comprehensive plan in situ to manage this situation. In the first instance the RGNs on site, would be consulted to complete an assessment, whereby specialist palliative health professionals would be contacted to seek their input. Families, and the person, as far as possible would be asked to be involved in making decisions. A comprehensive plan would be developed and reviewed continually. People's religious and cultural preferences would be adhered to and respected by all staff. The clinical lead would take the principal role in end of life care, directing and managing staff.

Requires Improvement

Is the service well-led?

Our findings

At our inspection of October 2017, there were multiple breaches within this domain, leading to a rating of inadequate. At this inspection we found that sufficient progress had been made to change the rating to Requires Improvement.

At the last inspection the service was in breach of Regulation 18 of the Registration Regulations 2009. We had not received notification of incidents as required. At this inspection we found that the service had ensured they had within an appropriate timeframe informed the CQC of any notifiable incidents. We had received notifications and updates to these from the registered manager as required. The information was reflective of the incidents that were reported, and when further information was requested the registered manager was forthcoming with this. We liaised with other professionals that needed to be kept informed of incidents and were told that information was provided as required. The service was therefore no longer in breach of Regulation 18 of the Registration Regulations 2009.

At the October 2017 inspection we found the service to be in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that specifically focuses on the duty of candour. We had found that in several incidents where people had sustained serious injuries, the principles of the duty of candour had not been applied. However, at this inspection we saw evidence that the guidelines of the duty of candour had been followed. The service had acted openly and transparently, notifying the relevant person of the incident. An accurate account of the incident including any further enquiries, an apology and a written record were maintained securely by the service. These were available for us to review, and further illustrated that the service was no longer in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that specifically focuses on good governance, at the last inspection. We found that whilst some improvements had been made with governance, other issues remained prevalent. The provider remained in breach of this regulation.

The provider had not ensured that the service received adequate management and leadership following the last inspection. Although a new registered manager was appointed in January 2018, due to unforeseen circumstances they were absent from the service for a period of approximately eight weeks. In their absence the service was managed by an agency interim deputy manager, who left prior to the registered manager's return to the service at the end of March 2018. During this time the CQC received information of concern relating to the management of the home and the associated impact on people's care. The issues highlighted related to the management of the home and the support given to the staff in the absence of the registered manager. The CQC raised these issues immediately with the local authority provider. A meeting was called to discuss these concerns. It was found that whilst an overview was maintained by the provider, the lack of consistent presence of senior management at the service had left staff feeling vulnerable. This view was mirrored by relatives. At the inspection we were told by a relative, "the registered manager seems good, but when she was off work, we thought the service was going to keep slipping. An interim manager was in place,

but they were agency and just left." Another relative reported, "We raised concerns with the deputy manager but they didn't seem interested. They were here one minute the next they were gone. We weren't even told they were leaving." The service now consisted of a new interim deputy manager, a clinical lead who was then overseen by the registered manager. It was hoped that by having a stronger senior management team the service would operate better and their presence would be seen within the service.

At the last inspection we found an issue with water temperatures not being monitored or recorded prior to use. A document was in place at the October 2017 inspection for staff to record water temperatures. However, we found many of the documents were left blank or had been completed inconsistently. At this inspection we found the concern remained prevalent. Although thermometers were available on each floor in communal bathrooms, staff failed to accurately record water temperatures prior to assisting people with personal care. Of the nine files we case tracked, we found none had consistently monitored and recorded water temperatures. The audits currently completed by the registered manager had not determined that documents created for staff to record information were not being appropriately used. The service had an electronic system in place that monitored and stabilised the water temperature at a central point. The maintenance person weekly checked two different rooms to ensure the water was safe to use and the electronic system was functioning as it should. The additional water temperature checks by staff was aimed at ensuring that should the thermostatic valves not be working, staff would be aware of this and thus not place people at potential risk, by using water that was too hot. If water temperatures are not adequately controlled and checked this also poses the risk of legionella bacteria causing potentially fatal infections. We found that staff were not appropriately checking the water temperatures when assisting people with personal care. This had further not been picked up within any audits completed by management.

The service was more stable since the return of the registered manager in mid-April 2018. However, the registered manager reported that she did not feel the service was at a stage where it would be stable in her absence. A permanent deputy manager was offered employment, however prior to taking the position they withdrew. An interim deputy was appointed and commenced work on the second day of our inspection. This was an internal transfer. The post was due to be advertised in December 2018. The clinical lead had been working at the service for several months as an agency worker, and had taken the permanent role some four to five weeks prior to the inspection. This meant the management team was still in its infancy, and it was too soon to be sure that consistency would be maintained. However, the registered manager did have the necessary skills to make changes to the service but was reliant on the provider assisting with this process. We saw evidence of issues being identified and raised with the provider by the registered manager in January 2018. Some of these issues remained unresolved at the time of the inspection. The registered manager had kept a comprehensive audit of all communication with the provider, for example when seeking assistance and authorisation for specialist equipment for people. This responses had not been timely which potentially put some people at increased risk.

We noted improvement in the level of agency staff usage since the last inspection of October 2017, where 62% of staff were agency workers. At this inspection usage had fallen to 48%. This meant a number of vacancies remained present. Although consistent agency workers were sought, they were not employed by the service.

The registered manager had developed systems and processes to monitor compliance with regulations. However, whilst these audits had been completed, they did not necessarily pick up all important issues. For example, audits of people's files had not picked up errors in the care plans and risk assessments. The audit checked whether these documents were in files and whether a date and signature indicated a review had been completed. The content and accuracy of the document was not checked. Further, the audit did not illustrate whose files had been reviewed. This meant the registered manager could not go back and monitor

whether any progress has been made, if required. We further noted that the audits did not have any method of monitoring that staff were maintaining people's dignity and treating them with respect. This meant that the registered manager may not identify shortfalls in this area, and then be able to address these as required. In addition the lack of staff file audits meant that the registered manager was not aware of the issues that were prevalent within these. By not auditing these, the registered manager was unable to reassure herself and us that staff were safe to work with people.

Some audits were in the process of being developed, so their effectiveness could not yet be measured. For example, whilst medicine audits had commenced, these were in their infancy and had not appropriately picked up errors identified during the course of this inspection (please refer to the safe domain). Other audits required cross referencing across several documents to ensure work was being completed as required. For example, the house keeping audits were completed in three separate booklets. Many of the points were covered in all three books, however, only signed off in one book. This meant that in order to review the housekeeping on the second floor, documents related to the first and ground floor also needed to be reviewed. The registered manager acknowledged this was not an effective way of monitoring the service. The service remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fire checks had been completed appropriately. This included, fire equipment checks, panel checks, sounding the alarm and practice drills. Personal emergency evacuation plans (PEEP) existed for people on all floors; these were updated and reviewed to ensure they were accurate. We did find an issue with inconsistency in fire procedures. The document read that the process should be completed within a two to three minute window. However, we found since the drills had commenced the process took an average of six minutes. The document clearly indicated a review should be completed with the appropriate professionals if targets were not achieved consistently. We spoke with the registered manager regarding this who acknowledged that given the needs of people this was an unrealistic target. The documentation needed to be updated, and had not been appropriately reviewed to ensure this was actioned.

The registered manager had a clear vision and values of the service, and had communicated these to staff. We saw an improvement in staff morale. Team meetings were completed frequently and staff were given the opportunity to speak with the registered manager and clinical lead at any point during the day. The registered manager operated an open door policy. The registered manager ensured any visitors attending the service saw she was present on site, and where possible would greet visitors personally seeking feedback. Quality assurance surveys had been distributed to people, relatives, staff and stakeholders seeking feedback on improvements the service could make, and how the service was currently performing. This information had not yet been analysed, although trends had been noted some actions taken. The ratings of the last inspection were clearly displayed in the premises.

The registered manager ensured the principles of EDHR were practiced and upheld within the service. Policies were reviewed regularly and any protected characteristics of people and staff were respected. Where necessary measures were employed to enable people to live an independent life as possible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that the care and treatment of service users, was appropriate, reflective of their needs and preferences. The registered provider was unable to illustrate that reviews had taken place with the service user and that the care plans focused on their needs. Regulation 9 (1)(a)(b)3(a)(b)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider did not ensure hat service users were treated with dignity and respect. Measures had not been taken to support their autonomy, independence and involvement in the community. Regulation 10 (1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that service users were treated in a safe way. Risks were not appropriately assessed or actions put in place to mitigate these, medicines were not available in correct quantities, were not safely or properly managed and the registered provider failed to assess, detect and control the possible spread of infections. Regulation 12(1) (2)(a)(b)(f)(g)(h)(I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not ensure they had systems or processes in place to establish and operate effectively and be compliant with legislation. Regulation 17(1)(2)(b)(c)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider did not ensure that people employed were fit and proper to carry out their duties in accordance with the regulated activity safely. Regulation 19(1)(a)(b)(c)(2)(a)