Beech Meadows Homes Limited

Kingsthorpe View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Kingsthorpe View Care Home on 10 April 2018. The visit was unannounced. We returned announced on 11 April 2018.

Kingsthorpe View Care Home is registered to provide accommodation, nursing care and personal care for up to 50 older people. The home is on two floors with various communal areas for people to sit and meet with relatives. There were 33 people living at the home at the time of our inspection.

The service did not have a registered manager. 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 provider had recruited a new manager and they were due to register with CQC.

Since the new manager has been in post there have been a number of extenuating circumstances beyond the provider and new manager's control. These have caused a number of problems in managing the service effectively. These have included staffing issues, a fire and total heating system failure. The fire had happened as a result of a person, who now no longer uses the service setting fire to their bedroom. Swift and appropriate action was taken by staff to ensure people were safe.

A new heating system had been installed due to failure of the previous system.

Not all areas of the service were clean and hygienic. This included communal areas, bathrooms and toilets. The environment was not always suitable in maintaining people's privacy as some toilets and bathrooms did not have locks fitted.

People using the service told us they felt safe living at Kingsthorpe View. Relatives we spoke with agreed their family members were safe living there.

The staff team were aware of their responsibilities for keeping people safe from avoidable harm and knew to report any concerns to the management team.

Risks associated with people's care and support had been assessed but had not always reviewed and updated following an incident. Where risks had been identified these had, wherever possible, been minimised to better protect people's health and welfare.

Appropriate pre-employment checks had been carried out on new members of staff to make sure they were safe and suitable to work there. Suitable numbers of staff were deployed in order to meet people's needs.

New staff members had received an induction into the service and on-going training was being delivered.

This enabled the staff team to gain the skills and knowledge they needed to meet people's needs. The staff team felt supported by the acting manager and were provided with the opportunity to share their views of the service. The acting manager had yet to implement regular supervision for all staff.

People were supported with their medicines in a safe way. Where people received covert medicines appropriate consultation with the pharmacist had not taken place. Where people needed their medicines prior to eating or taking other medicines, it was not always clear which staff had the responsibility to administer these particular medicines. Where people were living with dementia there was no guidance to ensure they received appropriate pain relief if they were unable to tell the nurse they were experiencing pain.

The acting manager had assessed people's care and support needs prior to them moving into the service to make sure they could be met by the staff team.

The staff team supported people to make decisions about their day to day care and support. They were aware of the Mental Capacity Act (MCA) 2005 and Liberty Protection Safeguards (LPS) ensuring people's human rights were protected.

People's food and drink requirements had been assessed and a balanced diet was being provided. Records kept for people assessed as being at risk of not getting the drinks they needed to keep them well, were not always kept up to date.

People were supported to maintain good health. They had access to relevant healthcare services such as doctors and community nurses and they received on-going healthcare support.

The staff team were kind and caring and people's privacy and dignity was respected and promoted.

The area where people could go to smoke was not ideal due to the fire door being left open and cold air and smoke coming into the lounge. We have made a recommendation about the siting of this area.

People had plans of care, however these were not personalised and did not reflect the individual care staff actually provided.

Activities did not always reflect people's interests and hobbies. So opportunities had been missed to provide good stimulation to people and keep them from being bored.

A formal complaints process was displayed and people knew who to talk to if they had a concern of any kind. Complaints received by the provider had been appropriately managed.

Relatives and friends were encouraged to visit and they told us they were made welcome at all times by the staff team.

The provider has not carried out a survey to involve people in the running of the service provided.

Systems in place to monitor the quality and safety of the service being provided were not always effective.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Not all areas of the home or equipment used were clean and hygienic.

People's medicines were not always provided to people following good practice guidelines.

Risks associated with people's care and support was not always reviewed following accidents or incidents.

An effective recruitment process was followed and sufficient staff deployed.

People told us they felt safe. The staff team knew their responsibilities for keeping people safe from avoidable harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Although people were supported with their nutritional and healthcare needs staff did not always effectively monitor fluid intake for people at risk of dehydration effectively.

People's needs had been assessed before they moved into the service to ensure that staff were able to meet the person's needs.

People received support from a staff team who had the necessary knowledge and skills to provide effective care.

The staff team understood the principles of Mental Capacity Act 2005.

The environment is not always suitable to meet people's needs.

Is the service caring?

Good

The service was caring.

The staff team were kind and caring and they treated people with dignity and respect.

People had been involved in deciding what care and support they needed.

Information about people was kept confidential.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not consistently involved in the planning of their care with the support of their relatives.

The people's care plans did not always reflect the care they required or what was provided.

People did not always receive age appropriate activities.

There was a formal complaints process in place and people knew what to do if they were unhappy about anything.

Whilst staff had a good understanding of how to provide good end of life care it was not always explored with people.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Monitoring systems used to check the quality of the service being provided were not effective.

The staff team working at the service felt supported by the registered manager.

People were not given the opportunity to share their thoughts on how the service was run.

The acting manager worked in partnership with other organisations including the local authority and safeguarding team.

Kingsthorpe View 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 10 April 2018 and was unannounced. We returned announced on 11 April 2018. The inspection was carried out by an inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was people with dementia. This was the service's first inspection since they registered with the Commission In March 2017.

We contacted the health and social care commissioners who monitor the care and support of people receiving care at Kingsthorpe View to obtain their views of the care provided. We also contacted Nottinghamshire Fire Service. We used this information to inform our inspection planning.

At the time of our inspection there were 33 people living at the service. We were able to speak with six people and four relatives of people living at the service. We also spoke with the provider, acting manager, the deputy manager, a senior carer, three care staff, the activities organiser, the cook and housekeeper.

We observed support being provided in the communal areas of the service. This was so we could understand people's experiences.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed a range of records about people's care and how the service was managed. This included six people's care plans, associated documents including risk assessments. We looked at records of meetings, recruitment checks carried out for three support workers and the quality assurance audits the management team had completed.

Requires Improvement

Is the service safe?

Our findings

People told us they received their medicines when they needed them. One person said, "The nurse is good. She brings my tablets and a drink of water and waits until I've taken them." Another person told us, "I don't know what my tablets are, but they wouldn't bring them if I didn't need them. They bring them in the morning, at lunchtime and at night."

Medicines were being stored safely in a locked room. Temperatures of the room and medicines fridge were being recorded daily. Records were legible and being recorded appropriately. One medication record did not have a photograph of the person whose medicines they were referring to, to enable identification. The manager told us that the person had only recently moved to the service and a photograph would be taken shortly to add to the records.

We observed part of the administration of medicines in the morning. The nurse followed correct and safe procedures when administering people's medicines. The whole process was unhurried. The nurse told us that they had attended medicines management/administration training and had their competency assessed when they started. Training records confirmed this.

There were some people who needed their medicine in the morning 30-60 minutes before food and other medicines to ensure their effectiveness. We noted that the service did not appear to have consistent arrangements in place to ensure these specific administration instructions were followed. We discussed this with the acting manager who told us that routinely the night nurse would administer this medicine. They stated they would ensure that this was recorded on the night nurses' task list to avoid confusion.

One person received their medicines covertly to ensure they remained in good health. (This may be hidden in food as they may refuse the medicine). However, the care records did not show clearly how this decision had been made or whether it was in the person's best interests. A best interests meeting had not been held or a mental capacity assessment recorded. The advice of a pharmacist had not been sought as to the suitability to disguise medicines in the manner proposed. The decision to continue administration of the medicines covertly was not regularly reviewed to assess whether this method was still necessary. Care plans did not reflect the safeguards that were in place to ensure all the medicines were taken by the person it was intended for.

Some people were prescribed 'as and when' (PRN) pain relief. Where the person had problems of understanding and communicating records did not indicate how their pain was assessed. For example, care plans did not describe specific behaviours for staff to consider if the person was in pain. This meant there was a potential risk that people could go without pain relief when they needed it.

The provider had failed to ensure that medicines were being administered as required and in the best interests of people. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a fire in March 2018, which we were notified about. As a result of the smoke and water damage a major refurbishment work was taking place. However, the service was generally not clean; we found dirt and debris including chocolate wrappers down the back of radiators which may have been a fire risk. Flooring in many areas was not sealed to the skirting boards and debris had accumulated. The hard flooring in some lounges had ingrained dirt around the edges. Each lounge had a small kitchenette; we found open cereal packets that were not always in appropriate containers. Fridges in these areas were dirty. One had sandwiches in, which were not dated and another had a bowl with unlabelled contents. We noted that medicine pots were being dried on the top of radiators. There was dirt around taps, toilet brushes were worn and not clean. There was a bar area in one of the down stair lounges. This was also dirty and sticky. Items such as balls and equipment had also left behind the bar which made this area an unsafe tripping risk.

During the morning we saw that staff had left towels in bathrooms, ready for when people had a bath or shower. These were threadbare and fraying around the edges. We discussed this with the acting manager who told us that they had ordered more bedding and towels for people and this had been delivered.

We looked at cleaning audits and found multiple gaps within the records. This meant the acting manager could not be sure if appropriate cleaning was taking place.

The organisation of the laundry area was not safe. There was a risk of cross contamination as there was no one way system where soiled laundry came in one side and clean laundry left through the other side. The room was small; there was only a small gap between the industrial rotating press, which did not have a safety guard and could potentially lead to a risk of staff clothing getting accidentally caught up when passing. The area behind the machines was dirty and had clumps of fabric fluff, which was a potential fire risk. The room had no ventilation and was uncomfortably warm with all the machines on and the industrial press. We discussed this with the provider who told us they would make arrangements to improve the general housekeeping.

The infection control audits we saw had not identified the areas of concern we found. We discussed this with the provider and acting manager who told us they had identified these issues but due to the fire they had been concentrating on the subsequent refurbishment. The acting manager provided us with a provisional action plan following the inspection showing what had been identified and timescales to make the improvements.

We recommend that the service consider improving their infection control audits to ensure areas are identified and action taken in a more timely manner.

People we spoke with told us they were happy with the cleanliness of their bedrooms and had access to baths or showers when they wanted. A relative we spoke with said they thought their loved one's bedroom was always clean and had no concerns about the general cleanliness of the service. They told us, "The home is clean, [person] bedroom is clean."

Risks associated with people's care had been assessed for nutrition, falls, tissue viability, moving and handling and choking. However these were not always regularly reviewed or reviewed in response to incidents. For example, one resident had had four falls over the previous four weeks. Their risk assessment had not been reviewed following these. Another person who had fallen sustaining head and facial trauma did not have their risk reassessed until three days later. The person had received appropriate medical attention however, there was no review to mitigate the same thing happening again.

People received care from a dedicated and caring team of staff. Most people we spoke with agreed that they felt safe while receiving support from staff. One person said, "I feel very safe and the staff look after me." Another person commented, "This is a very safe place."

When safeguarding incidents had occurred, the acting manager discussed these with the appropriate local authorities and took action where necessary to keep people safe from harm. For example the acting manager told us what action they had taken following a recent incident involving a member of staff. Records showed that the acting manager had followed local protocols and ensured people using the service were safe.

When we spoke with staff about people's safety and how to recognise the possible signs of abuse, these were clearly understood. Staff were confident about how they would report any allegations or actual abuse. One staff member said, "Even though we [staff] are like a family, I wouldn't put up with anyone mistreating the residents."

The recruitment process ensured that staff were suitable for their role and staffing levels were responsive to people's needs. We saw that staff were available when people needed them and that they did not have to wait to receive the support they needed. People mostly told us they thought there were enough staff. One person told us, "I'm never kept waiting. They come straight away if I need them." Another told us, "They come quite quickly. They don't keep me waiting." Only one person told us they did not think there were enough staff. They said, "I don't think there's enough staff. I don't see too many." Staff told us they felt there were enough staff working to support people safely. "We have plenty of staff on duty." Throughout our inspection we saw staff in attendance, carrying out their care duties including talking with people. We heard call bells ringing throughout the day but they were answered promptly. People using the service did not raise any concerns about call bell response times.

The provider had systems in place to respond to accidents and incidents. We saw that when an incident or accident occurred, staff offered the required support. This included contacting the emergency services where necessary. One staff member told us, "If someone falls, we press the emergency buzzer. We don't move them and wait for the nurse to come and check them over. We would call for the emergency services if we needed them."

Accident and incident records were recorded on an electronic system. As the acting manager was new and received a limited handover they were struggling to analyse information to identify patterns in accident and incidents within the service. They showed us they were due to have further training on the system.

They were aware of the need to monitor all accidents and incidents and learn from them to ensure people's safety. For example, they were able to discuss the recent fire. They explained the learning from this incident and how they would reduce future risk. Prior to our inspection we had spoken with the fire officer involved in reviewing the incident. This had occurred when a person living at the service set fire to their bedroom. The fire officer was satisfied with how the staff had managed the incident and what learning they were taking forward. This included improving the pre assessment carried out prior to people moving to the service to ensure any concerns about people's mental well being were identified and risk assessments put in place.

The provider had systems in place to check the safety of the environment and equipment that people used to minimise risks to people's well-being. For example, we saw that checks occurred on the temperature of the hot water to prevent scald risks, on the fire system and on the safety of utilities such as the gas and the electric. Equipment to help them move from one position to another was serviced in line with manufacturing guidelines.

Requires Improvement

Is the service effective?

Our findings

People using the service had their care and support needs assessed. The acting manager explained that whenever possible an assessment would be carried out prior to a person moving into the service. This made sure their needs could be met by the staff team. They told us they would only accept people where they thought not only did the staff team have the skills to meet people's needs but that the person would fit in with other people using the service. They told us that despite having 13 vacancies the provider was supportive about not taking people into the service simply to fill beds. When we spoke with the provider they confirmed that filling the beds although important was not as important as getting it right.

People spoke positively about the skills and knowledge of the staff. One person told us, "They know what they are doing." Another said, "They are very good. They help me to get dressed and they are gentle."

New staff completed an induction before they worked with people on their own. A member of staff told us that their induction provided information about people that was personalised and ensured they had a good understanding of each person's needs.

Staff received training relevant to their role. A staff member told us, "We have access to training, we just have to ask. Plus there is the regular training we have to do that's updated regularly." The training matrix showed that staff had access to a wide variety of training to enable them to carry out their role. Nursing staff received training and clinical supervision specific to their role. This ensured they maintained their registration with the Nursing and Midwifery Council.

Staff told us that they don't currently receive supervision. We discussed this with the acting manager who told us due to all the issues experienced at the service since their arrival it had not been a priority. We were shown a supervision rota going forward for 2018 ensuring that all staff would be receiving supervision in the future. Staff we spoke with told us they did feel supported by the management team and felt able to speak with the acting manager or nurses if they needed to raise a concern or advice. The nurses told us they also felt supported by the acting manager who was a qualified nurse.

People were supported to eat and drink and maintain a healthy and balanced diet. Feedback from people on the quality of food was generally positive. One person told us, "I like the food. It's alright." Another person commented, "I think they are two different things at lunchtime. They ask what you want."

The service employed two cooks. The second cook started on the second day of our inspection and showed both enthusiasm and an understanding of providing nutritious meals for older people. They told us they intend to make changes to the menus to include seasonal foods to help people living with dementia to orientate themselves to the time of the year. They wanted to involve people and their relatives in menu planning. They also intend to consult with people on the meals provided.

We saw staff assist a person to eat their meal. This was done discreetly and the staff member took time and did not rush the person. They also maintained the person's dignity throughout, wiping the person's hands

and face to ensure they were clean and ensuring their clothes remained clean by asking if they could place an apron over them.

People were offered tea and coffee or cold drinks with biscuits from a tea trolley during the morning and afternoon. We saw fruit and snacks were available in the lounges meaning people could help themselves if they felt hungry. There were also jugs of fruit juice and beakers, some glasses looked stained and we did not see the jugs being refreshed at all during our visit. The acting manager told us they would ensure the jugs were refreshed regularly.

The acting manager showed us that they have recently agreed a contract with a company to provide picture menus and signage around the service to support people who may have a visual impairment.

Where people were at risk of dehydration fluid charts were not always in place. For example a person's care plan stated they were at high risk of regular infections and indicated that fluids should be encouraged. However, the daily records did not indicate that staff were consistently encouraging the person to drink or the amount of fluids they should be having to prevent dehydration.

Staff sought people's consent before providing care. We heard staff offer help, asking for example, "Can I help you with that?" and, "Are you comfortable?" One person said, "They are always asking me. I'd tell them if I didn't like anything." Another person told us, "They ask me everything."

The staff team monitored people's health and wellbeing and was responsive to changes in people's health needs. Records showed that there was input from health care professionals. For example the speech and language team and dieticians were contacted when people needed this support. The acting manager told us they had introduced a new healthcare support system for staff. Staff told us that they now contacted a telephone number and could speak to a health care professional directly. It had video capacity so the health care professional could both see and hear the person the staff member was calling about. Staff found this new system very helpful in ensuring people at Kingsthorpe View received timely healthcare support.

The Mental Capacity Act (MCA) 2005 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 were 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 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 are called the Liberty Protection Safeguards (LPS).

The staff team had received training in MCA and LPS and they understood their responsibilities around this. One staff member explained, "It's about ensuring that people have their best interests taken into consideration. We assume capacity to make a decision unless someone has been assessed as unable." Care plans showed that capacity assessments were taking place and looked at people's ability to make decisions.

People had access to both indoor and outdoor spaces. There were spaces available for people to meet with others or simply to be alone. Whilst these spaces were available, not all of the spaces including the enclosed garden, were well maintained. The acting manager and provider were aware of this and what needed to be done to make the necessary improvements.

The service enabled people who wished to, to smoke. However, this was outside an emergency exit near a lounge. During our inspection, two people were outside smoking and the emergency exit had been left open

to allow them to return inside when they had finished. This meant that not only was that lounge cold due to cold air coming in from outside but the smoke from outside was also being drawn in to the lounge.

We recommend that the service seek guidance on a more suitable area for people to smoke that does not impact on people using that lounge.

Good

Is the service caring?

Our findings

People told us the staff team at Kingsthorpe View were kind and caring and they looked after them well. One person told us, "They're lovely people." Another person said, "They are nice, and you can have a laugh with them." Relatives we spoke with were also positive about staff. One relative said, "Staff are kind, they are bubbly." Another relative commented, "I'm always made to feel welcome. The carer's are good and respectful."

Staff we spoke with told us there were enough staff on each shift so they could spend time talking with people not just carrying out tasks. We observed the staff team supporting people and support was carried out in a caring way, including chatting with the person. Staff were discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively. Staff offered reassurance and explanations when they helped people, such as assisting someone to stand.

Many staff at Kingsthorpe View had worked at the service for several years. As a result staff knew the people they were supporting and their preferred routines. They also knew the people who were important to them such as friends and relatives. This meant people received consistent care in a way they wanted.

People are encouraged to express their views and be involved in their care. Staff told us they knew people and understood what people needed. They told us they provided care and support as people preferred. One staff member said, "We always ask if they want us to help them. We don't just take over. It's about supporting them to stay independent." People confirmed that staff always asked what help or support they needed.

Staff knocked on people's doors and identified themselves on entering the room. Doors were closed when personal care was being given, ensuing people's dignity and privacy was maintained. Staff we spoke with understood their responsibility to maintain people's dignity during personal care. One staff member said, "We make sure we get people's things ready in the bathroom before we start any care. That way once we are there we don't have to keep going in and out. We always talk with them when we provide personal care. It helps relax people."

However, we did note that some bathrooms and toilets were not lockable. This meant that people could be using the facilities and anyone could walk in, compromising their privacy and dignity. We discussed this with the provider who told us they would make arrangements to have locks fitted to the identified bathrooms immediately. Following the inspection the acting manager confirmed that locks had been ordered and were due to be fitted at the end of the month.

Relatives told us they were able to visit Kingsthorpe View without undue restrictions. During the day relatives and friends visited people and staff always welcomed them. A relative commented, "I'm always made to feel welcome." Another relative told us, "I visit most days and they always make me feel welcome."

A confidentiality policy was in place and the staff team understood their responsibilities for keeping people's

personal information confidential. People's personal information was stored and held in line with the provider's policy.

Requires Improvement

Is the service responsive?

Our findings

People received care that met their individual needs based on their preferences and requirements. People told us they could spend their time as they wished and staff knew their likes and dislikes. Staff knew people very well and were able to tell us about individual people. They were aware of people's histories, where they had lived and their previous occupations.

Before people moved into the home, the provider carried out a pre-admission assessment. When people moved in, a care plan was developed. Not all the people we spoke with could recall being involved in their care plan. However, relatives we spoke with told us they had been involved in both the development and review of their loved one's care plan.

The main care records were in an electronic format. Staff had laptops available and visiting professionals could access information via these. Staff were also able to access the system remotely using electronic tablets or their mobile phones to make entries. There were supplementary files, which contained the DNAR (Do not attempt resuscitation), hospital letters and emergency grab care plan containing key information should the person need to be admitted to hospital. These records were stored securely in the nursing office.

The care record included risk assessments and the care plan and daily record of care. The risk assessments and care plan were not reviewed regularly and they did not show if the person or their relatives were routinely involved in the reviews. One relative told us that if they felt they needed a meeting they could speak with their loved one's keyworker and it would be arranged. We discussed the care planning system with the acting manager and the provider. They said they were looking into more training for staff to help them use it more effectively.

The care plans were not person centred, however all the care staff and the nurse we spoke with knew how to care for people in a very person centred way demonstrating that they knew everyone's individual routines, likes and dislikes on dressing and food preferences. One staff member told us, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right."

The home had an activity programme and employed two activity coordinators. On the day of our inspection the chair exercises on the programme did not take place. We also noted that the age appropriateness of some of the activities were questionable as one person was sitting with a pile of child's building blocks in front of them. People mostly either sat in their chair or walked around the service, this could indicate they were bored and did not feel engaged in activities offered. We were told by the acting manager that more activities were usually on offer but the second activities person was on annual leave.

Staff told us they felt that they needed more equipment to support activities with individuals as they recognised that due to people living with dementia it was difficult to get them involved in groups. Staff all felt that the loss of the mini bus when the home changed ownership, had limited their ability to take people out and into the community. We saw photographs of previous outings to the seaside as well as Matlock and pub outings. A relative we spoke with said they appreciated the work that the activities organisers did to

encourage their loved one to do things. They told us, "I don't know her name but the activities organiser deserves a gold medal. She is really good. She is very placid, works really hard." However another relative said, "I think this is an area they are a bit slack in. [Person] will have their nails painted and some knitting, but group activities are difficult." The acting manager said there were plans to do more work with the activities coordinators to develop their role.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The acting manager had recently agreed a contract with a company to provide menus and signage in a more appropriate way.

People's views, beliefs and values were respected. For example, people were supported to follow their faith. A relative told us people visited from a local church and would lead people in hymns and prayers if they wanted to join in. Staff told us how they met individual needs of people with a range of religious beliefs, for example relating to individual spiritual support, dietary requirements and personal care. A relative told us a staff member had arranged for culturally appropriate meals to be brought in for their loved one. [Person] really likes it. We really appreciate it as well."

People were supported by staff to maintain their personal relationships. This was because staff understood people's life history, their cultural background and their sexual orientation.

The provider had a complaints procedure in place. People and their relatives knew how to make a complaint or to raise a concern should they have needed to. A relative told us, "If I needed to, I would speak to the manager."

End of life care was not routinely being discussed with people or their relatives. This meant there was a lack of advanced care planning. Staff we spoke with knew the importance of end of life care and were able to describe how they would provide appropriate care. Staff had also identified the need for an end of life suite to help support relatives to be with their loved one at this stage in their life. The provider had supported this and a room had been set aside and tastefully decorated. It provided a calm environment and a sofa bed enabling relatives to stay overnight if they wished.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place. 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.

There had been a number of serious events since the provider took over the service in 2017. The provider had taken appropriate action to minimise the disruption to the service, including recruiting a new manager. However the new manager had yet to register with CQC. They told us they were aware of the urgency to register and would be submitting an application.

The service unexpectedly lost its heating system during winter 2018. The provider took immediate action and had a complete new system installed. This included a back up system in the event the main system failed in the future. This showed that the provider took action when issues were identified.

The acting manager had a number of quality assurance documents that looked at different aspects of the service. However, these were not always completed well and did not identify the issues we found with infection control or medicines management. For example we found that the cleaning rota was not being completed consistently and areas of the service were dirty.

Although both the provider and acting manager were aware of the shortcomings within the service they did not have a robust action plan in place to show what actions they were taking or time scale to complete. The acting manager did provide us with an action plan following the inspection, which indicated the provider would be taking action to improve the environment and overall service during the next 12 months. This included the current refurbishment required following the fire. The provider was also ensuring the acting manager had time to make the improvements by not expecting them to fill the vacant beds quickly.

People and their relatives told us that the service was well-led and that the acting manager was approachable. One person told us, "I know who the new manager is, she's very nice." A relative told us, "The new manager introduced herself to us and we find her very approachable." Another relative told us, "I have confidence in this new manager."

The service had a positive ethos and an open culture. Staff spoke very positively about the acting manager. One staff member told us, "We have had managers in the past who want to be one of the girls and it never worked. They ended up having their favourites and so on. This manager is not like that. She is very approachable, but you know that she is in charge. She has a heck of a mountain to climb. There is so much that needs doing here. It all needs decorating and, of course, the fire has meant that there is a lot of reconstruction going on. She is really doing her best though." Another staff member said, "We are encouraged to share our concerns if we have any."

We saw that the provider had taken action to refurbish the areas affected by the fire. Steps had been taken

to minimise the disruption to people and staff using the service. This included closing off one corridor where the bedrooms affected were located. People and their families had been involved in the decision to move to other bedrooms. This ensured disruption caused by noise and dust was kept to a minimum. The provider was liaising closely with the acting manager to ensure the necessary improvements were taking place.

The staff team felt supported by the acting manager and the management team. They explained there was always someone available to speak with if they needed to discuss anything. The nurse and the care staff said there were plans for regular staff meetings and they had recently attended a meeting with the provider and acting manager to discuss the future of the service. They also told us the acting manager holds daily meetings with heads of services, nurses and senior carers, which the staff felt were useful and productive. The acting manager told us that they held these meetings to ensure everyone knew what was going on and relevant information was shared, whether it was regarding a new person moving to the service or an update about the refurbishment.

Staff knew about the provider's aims and objectives that people could expect when they used the service. A staff member told us, "We are here to make sure people are safe and comfortable, provide personal care and ensure they have good life."

The acting manager worked openly with stakeholders and other agencies. This included raising safeguarding alerts and liaising with social work teams and other professionals when appropriate to ensure people's safety. Prior to our inspection we spoke with the local clinical commissioning groups (CCG). We were told the service works closely with them to improve the service provided to people.

Due to a number of unforeseen issues that had occurred since the new manager came into post, the provider has not carried out a quality questionnaire in the last 12 months. However, the acting manager was aware that obtaining stakeholders' views was important and they needed to arrange a survey as soon as possible.

The registered manager was aware of and understood their legal responsibility for notifying CQC of deaths, incidents and injuries that occurred for people using the service. This was important because it meant we were kept informed and we could check whether the appropriate action had been taken in response to these events.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were being administered as required and in the best interests of people. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.