

Parkcare Homes Limited

Jubilee Gardens

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

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 site visit took place on 11 and 12 December 2018 and was unannounced.

Jubilee Gardens is a 'care home'. 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.

Jubilee Gardens accommodates up to 50 people in one adapted building. The home has two floors. It provides residential and nursing care to older people who live with dementia. During the first day of our inspection visits 43 people lived at the home and one person was in hospital. On day two 42 people lived at the home. The home is located in Castle Bromwich, West Midlands.

We last inspected Jubilee Gardens in December 2017 and gave the service an overall rating of 'Requires Improvement'. The inspection identified breaches of Regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not always enough staff available to keep people safe, risk associated with people's care was not safely managed and the provider's quality monitoring systems were not effective.

Following that inspection, the provider sent us an action plan, and which confirmed the actions required to make improvements would be completed by the end of March 2018.

At this inspection we found the provider had not fully addressed the issues we identified at the last inspection. We also found areas where the home had previously performed well had not been maintained.

This is the second consecutive time the home has been rated as Requires Improvement.

The service did not have a registered manager. A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had appointed a new manager who was planning to apply to register with the Care Quality Commission (CQC). They had been in post for three weeks at the time of this inspection.

People did not always receive safe care because some known risks continued to be inconsistently managed and other risks we found had not been assessed. Action was taken to address this.

Staffing levels continued to affect the standard and consistency of care people received because there were not always sufficient numbers of staff available when people needed them and to keep people safe. Despite

this people told us they felt living at Jubilee Gardens.

People's medicines were not always managed and administered safely.

The management team and staff worked in partnership with other professionals to support people to maintain their health and well-being. However, recommendations made by health care professionals were not always followed and staff did not always make timely referrals to health care professionals when needed.

Improvements had been made to the accuracy and level of detail in some people's care records. However, further improvement was required to ensure staff had the information they needed to provide safe care. Action was planned to address this. Most staff demonstrated a good understanding of the needs and preferences of the people they supported.

Staff were recruited safely and received an induction when they started work at the home. The provider supported staff through a programme of on-going training. However, staff had mixed views about the training they received. Improvements had been made to ensure staff had the opportunity to meet with the management team to discuss their role and development needs.

Management systems to check, monitor and improve the quality and safety of the service remained ineffective. Most people and relatives felt the home was well managed. The provider sought feedback from people and relatives. However, it was not clear how feedback provided was used to make improvements to the service provided.

Staff understood how to protect people from abuse and their responsibilities to raise any concerns. However, the management team had not consistently followed safeguarding procedures.

People and relatives felt most staff were caring and kind. People, mostly, received their care and support from staff who they knew. Significant improvements had been made to the opportunities available to people to take part in meaningful activities.

People's dignity was, at times, compromised. Relatives and friends could visit the home at any time and people were encouraged to maintain relationships which were important to them. Complaints were managed in line with the provider's procedure.

The provider was working within the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, some staff were not clear about authorised restrictions on people's liberty.

Staff gained people's consent before they supported people and respected people's decisions and choices. Staff respected people's privacy and supported people to maintain their independence.

We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

People were not always protected from the risk of significant harm and medicines were not always administered safely. Specific health conditions were not always managed in line with GP's instructions. Staff were recruited safely but sufficient numbers of staff were not always on duty. Staff did not always follow good infection prevention practice. Staff knew what action to take in the event of an emergency. Despite our findings people and their relatives felt the care that they received was safe.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Staff received an induction and most staff had completed the training they needed to be effective in their roles. The provider was working within the requirements of the Mental Capacity Act (2005). People's needs were met by the design of the building and people liked the food available. However, some staff had limited knowledge of people's dietary needs and recommendations health professionals made were not always followed.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

People told us most of the staff were kind. Most staff enjoyed their jobs and they spoke fondly about people. Staff sometimes found it difficult to maintain people's dignity. People were supported to be independent and maintain relationships that were important to them.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People did not always receive the care and support they needed. Most staff knew people well. However, communication between staff required improvement. Most people's care plans included a

brief life history and information about their preferred routines and lifestyle choices. People and their relatives knew how to make a complaint and most felt comfortable to do so. People took part in activities they enjoyed.

Is the service well-led?

The service was not consistently well led.

People and relatives felt the home was well run. However, the home was going through a period of instability and further management changes had occurred. Staff felt the home was not well led and they did not feel supported by their managers. Despite action being taken to make improvements systems in place to review the quality and safety of service were not yet embedded and were not effective. Further action was planned to make improvements.

Requires Improvement 

Jubilee Gardens

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.

The inspection was undertaken because when we last inspected the service in December 2017 it was rated 'Requires Improvement.' This inspection was to check improvements had been made.

Inspection site visits took place on 11 and 12 December 2018. The first of the visits was unannounced and the inspection team consisted of two inspectors, a nurse specialist and two assistant inspectors. Two inspectors returned on the second day to complete the inspection.

Prior to the inspection visit, we spoke with the local authority and Clinical Commissioning Group (CCG) who funded the care some people received. Both confirmed they continued to closely monitor the quality and safety of the service provided.

As part of planning we reviewed information we held about the service. We looked at the statutory notifications the service had sent us. A statutory notification is information about important events, which the provider is required to send to us by law.

We also used the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about what the service does well and improvements they plan to make. During our inspection visits we found some of the information contained in the PIR did not accurately reflect how the service operated.

Some people we spoke with were not able to tell us in detail about their care and support because of their complex needs. To help us understand people's experiences of the service we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not speak with us.

During our inspection visits we spoke with six people, seven relatives of people and two visiting professionals. We also spoke with 26 members of staff. This included three nurses, one clinical lead nurse, twelve care assistants, the maintenance worker, the administrator, an activities co-ordinator, the chief operating officer, the home manager, the deputy manager, two operations directors, the assistant director of nursing and the provider's quality improvement lead.

We looked at 11 people's care records and other records related to people's care, including medicine records, care plans and risk assessments. This was to see how people were cared for and supported and to assess whether people's care delivery matched their records.

We reviewed three staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also looked at records of the checks the provider and manager made to assure themselves people received a good quality service.

Is the service safe?

Our findings

At our last inspection in December 2017 we found breaches in Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to safe care and treatment and the management of risk and safe staffing levels. Following that inspection, the provider sent us an action plan which provided assurance they would meet the regulations by the end of March 2018. At this inspection, despite the provider's assurance, we found whilst improvement actions had been taken, these were not effective. Furthermore, areas where the home had previously performed well had not been maintained. The rating has changed to 'Inadequate.'

At the last inspection, the provider's systems to manage risks related to people's care and support needs were not effective. During this visit we found sufficient improvements had not been made.

People were not always protected from the risk of significant harm. For example, staff told us about one person who on occasions displayed physically and verbally aggressive behaviour. At these times staff said the person could cause harm to themselves and others. However, there was no risk management plan for staff to follow to mitigate the risk and to keep the person, other people and themselves safe.

Another person was at high risk of malnutrition and records showed they had lost five percent of their body weight between June and December 2018. A community dietician had completed a nutritional assessment on 3 December 2018 and had given staff instructions to follow to manage the risk. For example, monitoring the amount of fluid the person drank and making a referral to speech and language therapists to obtain further specialist advice. The instructions had not been followed which meant that risks to this person's health had not been managed or mitigated. Action was taken to address this during the first day of our inspection.

The management team had assessed another person to be at risk of causing themselves significant harm. On day one of our inspection we found the plan to manage this risk was locked in a draw in the manager's office which meant it was not accessible to staff. Furthermore, discussion with staff caring for the person, highlighted some staff were not aware of the risk. One staff member told us, "I didn't know [name] did that."

Whilst this ineffective management of risk was not known to have caused harm to people or staff it created a significant potential risk which was of concern to us.

We could not be sure the home's managers understood their responsibilities to report incidents of a safeguarding nature to protect people. This was because a safeguarding incident that had occurred on 3 December 2018 had not been reported to the local authority safeguarding team or the CQC as required. The management team took action to address this when we brought this shortfall to their attention.

Staff did not always recognise risks to people's health and wellbeing. At our inspection in December 2017, we saw an unattended hot food trolley in a communal area of the home which presented a risk of causing significant injury to people. During this inspection we saw a hot trolley with an operating temperature of 80

degrees in a dining room and no members of staff present. There were three people in the dining room, all of whom were living with dementia which affected their ability to understand danger and risk. We alerted a staff member of this risk who then remained in the dining room.

At our last inspection, medicines were managed and administered safely. However, during this inspection we found safe medicines management had not been maintained. Medicine administration records (MAR) were not always accurate or in place. On the first day of our inspection we found staff had failed to identify one person had not received three consecutive doses of their epilepsy medicine which placed the person at significant potential risk of harm. Despite the medicine being in stock staff had failed to identify the medicine had not been recorded on the person's MAR.

Medicines were not always administered as prescribed which meant we could not be sure people's pain was consistently managed. For example, one person was prescribed pain relief in the form of a patch to be applied directly to their skin. The prescribing instructions required the patch to be changed every seven days. However, records showed on two occasions staff had not changed the patch for 14 days. We were concerned because the person was living with dementia and they were not always able tell staff that they were in pain.

People's specific health conditions were not always managed safely in line with GP's instructions. For example, a GP had instructed a person's blood sugar levels should be checked prior to eating. On day one of our inspection, staff confirmed they had served the person's breakfast before checking their blood sugar levels. This meant staff did not have the accurate information needed to determine how much insulin the person needed. This placed the person at significant potential risk of harm.

This was a continued breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We immediately raised our findings with the management team who assured us they would take action to improve risk management. On day two of our inspection, we found the required actions had been taken.

Previously, the provider had not ensured there were enough staff to support people when needed and to keep people safe. During this inspection we found staffing levels within the home continued to be a cause for concern.

When we last inspected the service in December 2017 the provider was in the process of reviewing the 'tool' they used to determine how many staff were needed to keep people safe and meet their individual needs. At this inspection whilst we saw a new dependency tool was in use, we found the actual number of staff on duty did not always reflect the numbers identified as needed.

At the start of day one of our inspection, staffing levels were below those the provider had determined as being needed to keep people safe. Two staff members left their shift early without authorisation in accordance with the provider's policy. In addition, a staff member told us they had not received a response from the 'on-call' manager when they had tried to inform them a staff member had needed to leave the home during the night to accompany a person to hospital. We found staff in charge of the home, at that time, had not considered how to redeploy staff to ensure people's safety.

Staff told us they were concerned about the staffing levels. One commented, "There are only two of us [staff] on so when we are providing personal care there is no-one covering the floor." They added, "Some people are at risk of falling. I just came out of a bedroom and found [name] walking without her frame. It's a real

risk. It's not safe." The staff member told us they had shared their concerns with the management team but felt these had not been listened to. They said, "They (managers) say yes, yes, but I feel like they are looking right through me. Nothing changes."

Visiting professionals, we spoke with also shared concerns about staffing levels. One said, "I am worried about the level and high turnover of staff which means they don't get to know the clients [people]."

During our inspection visits we saw how the staffing levels resulted in people receiving unsafe care. For example, on day one at 7:30 am a person assessed as needing assistance from two staff to move safely received unsafe care and support. This was because they received personal care support from one staff member. The staff member told us, "I wouldn't normally do it as normally you need two [staff] but [Person] needed changing." We were concerned this had placed the person and the staff member at risk of injury.

On another occasion when a person closed their bedroom door, we saw a staff member quickly opened it. They explained this was because the person was at significant risk of harming themselves and needed close supervision to keep them safe. The staff member said, "I'm on my own so I need to keep the door open, so I try to keep an eye on everyone."

Records showed another person displayed verbal and physical aggressive behaviours, particularly when they were being supported with personal care. Staff described how during these times all three staff on the unit needed to support the person to keep the person and themselves safe. One staff member commented, "If it happens in an evening when only two staff are on, we have to ask the nurse for help. That's leaves no staff on the floor."

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Despite our findings, people and their relatives felt the care they received was safe and overall, there were enough staff to provide the care that they needed. A relative commented, "The staff are okay. [Person] is safe. There is a lot of agency staff, but I guess that's better than no staff."

Most staff understood people's care needs. One told us, "The nurses tell us about any risk and explain what we need to do, and it's written in the care plans." They added, "If something changes we get told at handover."

Discussions with staff assured us they understood their responsibilities in relation to infection control. However, we saw staff did not always follow good infection prevention practice to protect people from the risk of infection. For example, we saw staff carrying soiled laundry along the corridor. One staff member told us, "We always do this, we don't have anything to carry it in."

Since our last inspection, staff had received training in the provider's emergency procedures. Discussion with staff demonstrated they understood the actions they needed to take in the event of an emergency to keep people and themselves safe. The emergency plan in place to evacuate the building safely had been reviewed to ensure it contained correct information.

However, some staff told us they would not be able to follow the emergency procedure when staffing levels were low. One commented, "To be honest I don't know what I would do because a staff member from each unit should go to the fire panel, but I'm on my own, so I couldn't leave the residents." They added, "I wouldn't know what was happening." We shared this feedback with the home manager who assured us they would speak with staff and take action to address this.

Staff had received training in how to protect people from abuse, including their responsibilities to report any witnessed or allegations of abuse to the home manager. Staff told us they were confident any issues of a safeguarding nature would be investigated by the management team. One commented, "I would go back to the manager and check and if I wasn't happy I would contact CQC (Care Quality Commission)."

Recruitment procedures were in place to ensure potential new staff employed, were of good character and safe to work. Procedures included reference requests, identification checks and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that keeps records of criminal convictions.

Is the service effective?

Our findings

During our last inspection, we found improvements were needed to ensure the service was effective and this key question was rated as 'Requires Improvement'. At this inspection we identified some improvements had been made, but further improvement was required. The rating is unchanged.

People and their relatives had confidence in the skills and abilities of the staff. Comments included, "The staff know what they are doing most of the time", "They seem trained," and, "I can't fault the staff, one nurse on this unit is very good."

During this and our previous inspection, staff shared mixed views about the quality of the training they received. One staff member said, "I think the training is really good. I have worked in care before but when I did the on-line training it was like having a full refresher." In contrast another staff member described the computer-based training as 'a bit frustrating' because they couldn't 'check things out'. They added, "Face to face training is so much better. I find that sort of training really good."

Records demonstrated most staff had completed the training they needed to be effective in their roles. The overall training compliance score at the home was 85% which was below the provider's required target of 92%. Further training courses, including fire safety, mental capacity and infection control, were planned to take place following our visits to address this shortfall.

Systems and processes ensured new staff received the support and training they needed when they started work at the home. A recently recruited staff member explained their induction had included working alongside a more experienced staff member, reading people's care plans and 'learning' about the residents [people]."

The provider's induction for new staff included starting the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. This showed the provider was acting in accordance with nationally recognised guidance for effective induction procedures to ensure people received good care.

At our last inspection staff told us they did not have regular individual opportunities to meet with a member of the management team to discuss their work role and any training and development needs. At this inspection staff confirmed things were improving because individual meetings (supervisions) were taking place. One staff member said, "I have to say I don't have regular supervision, but I have had them, and more are planned. The problem has been all the management changes." Another staff member described supervision as 'helpful'. They said, "You are asked how you are coping and getting on with things and you talk about training." Records confirmed this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We found improvements had been made since our last inspection which demonstrated the provider was working within the requirements of the Mental Capacity Act (2005). People had been assessed to determine whether they had capacity to make their own decisions. Where people had been identified as not having capacity to make specific decisions about their care, appropriate discussions had taken place with those who knew the person well, to make decisions in their best interests. The outcomes of these discussions were clearly recorded.

People confirmed staff gained their consent before they provided them with any assistance. We saw throughout our visits this happened which demonstrated staff understood the principles of the MCA. However, some staff did not know who had an authorised DoLS in place or what process they needed to follow if they thought a person's liberty was being restricted unlawfully. Refresher training for staff to increase their knowledge was already planned.

People's needs were met by the design of the building. Directional signage assisted people to move around the home. People's en-suite bathrooms had wide doors which meant people who used wheelchairs and mobility aids could gain easy access.

People and relatives provided positive feedback about the food and dining experiences at the home. Comments included, "Food always looks lovely," and, "I get plenty to eat and drink here." We observed the lunchtime experience in one unit of the home and saw it was positive. The atmosphere was calm and relaxed, and people were offered a choice of meals.

Diet notification sheets which detailed people's dietary requirements were shared with staff who worked in the kitchen and prepared food. However, some staff had limited knowledge of what people liked to eat and drink or if they required specialised diets. For example, during our second visit a member of care staff who was preparing people's meals because the chef was not at work, demonstrated limited knowledge of how to fortify foods. For example, when we asked them how they would fortify soup they responded, "I don't know. I don't do soup." When we asked how they would fortify potatoes they responded, "You would have to ask the kitchen assistant, I don't fortify the potatoes." This meant people who were at risk of malnutrition might not receive the extra calories they required to maintain their weight.

People felt they received effective care, support and treatment from health professionals to maintain their health. One person explained this was because staff arranged for their GP to visit them if they were feeling unwell.

Records showed people accessed healthcare professionals such as opticians, dentists, chiropodists and GPs. However, we identified the advice and recommendations health professionals made were not always followed because staff had not always made required referrals promptly. This had resulted in the treatment some people received being delayed.

Is the service caring?

Our findings

At our previous inspection we rated this key question as 'Requires improvement'. This was because staff did not always have the time they needed to provide person centred care. During this inspection visit we found staff continued to have limited time to spend with people. The rating is unchanged.

People told us most of the staff were caring and showed them kindness. One person said, "I am 89 years old and am very happy here. The staff are very good to me." A relative commented, "You get the odd one (staff member) who can be a bit off, but not very often. I think the staff are just busy, so they can come across a bit rude or rushed but I don't take it personally."

Staff spoke fondly about the people they cared for and most told us they enjoyed their jobs. One said, "Knowing you have helped someone is special." However, two staff replied, 'No' when we asked them if they would be happy for someone they loved to live at the home. A third said, "Yes, because they would get good care. But no because there may not be enough staff to provide the care."

During our SOFI, staff practices demonstrated they cared about people. For example, a staff member said to one person, "Are you okay, do you want anything, do you need me?" The staff member then knelt on the floor by the person and stroked their cheek. The person held their hand out and the staff member gently squeezed it. The person responded positively to this by smiling. Following our observation, the staff member approached us and said, "You know, if there was more staff we could spend more time with people. They need company but staffing levels are set by the tasks we have to do rather than to meet social needs."

People told us the care they received maintained their dignity. For example, one person explained how when staff supported them to shower, they closed the door and the curtains. Staff were discrete when they asked people in communal areas if they needed assistance. They also respected people's right to privacy. One person, said, "When my visitors come we get privacy and they (staff) knock the door before they come in." We saw this happened during our visits. Staff told us, and records confirmed they had received training in equality and diversity, so they could fully support people's individual needs.

However, staff found it difficult to protect people's dignity in regard to continence care and were using the wrong type and size of continence product. Staff told us the stock of continence products people required was not always available. One staff member said, "This happens all the time. We have to use 'pull ups' belonging to [people's names] until the order comes in on Thursday." We raised this with the management team who arranged for supplies to be brought to the home. However, managers were unable to explain why action had not taken to ensure sufficient stock was available.

Staff encouraged and supported people to maintain their independence where possible. For example, at lunchtime during our first visit we saw staff supported people to cut up their food which enabled people to eat their meals independently.

People and their relatives told us they had opportunities to participate in planning and reviewing their care.

A relative explained they had previously had meetings with nurses to make sure their relatives' care met their needs.

People told us there were no restrictions on visiting times and their family and friends could visit whenever they wanted to. This helped people to maintain relationships that were important to them. A relative told us staff had invited them to join their relative for Christmas dinner at the home which they thought was a 'kind and thoughtful gesture'.

Is the service responsive?

Our findings

At our previous inspection we rated this key question as 'Requires Improvement'. This was because staff were not always available at the times people needed them and some care records were not reflective of people's needs. We also found people were not provided with opportunities to engage in meaningful activities. During this inspection we found improvements in some areas had been made. However, people still had to wait for staff to respond to their requests for assistance. The rating remains unchanged.

People did not always receive care that was responsive to their preferences and lifestyle choices. One person told us their spectacles had broken. They said this made them feel 'upset'. A record dated the 6 December 2018 showed the person had requested a visit from an optician. When we asked staff if this request had been made, they confirmed it had not. One staff member said, "It must have been missed." This meant the person had been without their spectacles, which they needed to enable them to see clearly, for five days. We immediately raised this with the nurse on duty who took immediate action to address this. When we shared our findings with the operations director they said, "That's an unacceptable time to wait. It should have been sorted out straight away."

Another person told us that staff had assisted them to get up at 6am during our first visit which was not in line with their wishes. They told us this meant they felt tired when we spoke to them at midday and staff had provided assistance at that time because it suited them.

Staff we spoke with demonstrated they knew people well. For example, they knew how one person liked to have their hair styled and that another person liked to eat fish and chips. However, staff told us because they were busy and there was not always enough staff on duty, people did not always receive the care and support they needed. One staff member told us, "Today in this unit there has been no time to give people mid-morning drinks. We have been working nonstop to get people washed dressed and up."

Agency staff were regularly used to cover staffing shortfalls whilst the provider actively tried to recruit new nurses and manage staff sickness in line with their procedure. A visiting professional told us the high use of agency staff was a concern because agency staff did not always know people well. They told us, "The other day a DoLS assessor (person who assesses people's mental capacity) was asking for information and the nurse told them they were agency so didn't know anything." They added, "I am concerned about what is going on with the quality of care here." The manager told us as a temporary measure the same agency staff were 'block booked' to address this issue. However, at the time of our visit we could not be sure this action was effective.

Prior to people living at Jubilee Gardens, the management team completed an initial assessment of people's needs. The deputy manager explained the information gathered during assessments was used to complete care plans.

At our last inspection some people's care plans did not provide staff with accurate information. This meant we could not be assured people received care in line with their wishes.

During this inspection we saw some improvements had been made. For example, most people's care plans included a brief life history and information about their preferred routines and lifestyle choices. In contrast other care records, were not sufficiently detailed. The chief operating officer explained further action was planned to ensure all care records contained accurate, detailed information and were regularly reviewed.

Previously, staff told us they did not always have time to read people's care plans because they were busy. During this inspection staff told us this continued to be the case. One staff member said, "You do get time when you start working here, but after that you are so busy helping the residents you don't have time to sit down and read." They added, "We rely on the information we get at handover."

During the morning of our first visit we saw two nurses shared important information with each other about people who lived in one of the four units. This ensured the nurse coming on duty had up to date information about each person and could share information with the staff who would be providing care and support.

In contrast, on another unit communication between staff was not effective. This was because the nurse coming on duty had not received a handover of information. They told us, "I was told nothing at all expect one person may have a UTI (urine infection)." We asked them if they knew about the risks associated with people's care and they replied "No." They added, "I didn't even know one person was diabetic until the girls [care staff] told me." When we shared this with the chief operating officer they told us, "There are written handover notes for staff to read." However, we saw the handover record had not been completed.

When discussing communication with a visiting professional they told us this was an area they felt needed improvement. They gave the recent example of raising concerns about the quality of care a person had received with the management team. They told us they had shared their concerns four days ago and were still waiting for a response.

At the last inspection people were not always supported to follow their interests and take part in activities they enjoyed. During this inspection we saw the activities team had worked hard to make significant improvements. People participated in a variety of activities during our visits which included, pet therapy and a visit from a local church group. An activities coordinator explained how the 'creative minds' training they had completed had supported them to develop activities for people living with dementia such as, reminiscence sessions.

People and their relatives knew how to make a complaint and most felt comfortable to do so. A copy of the provider's complaints procedure was displayed within the home which included information about how to make a complaint and what people could expect if they raised a concern. Records showed complaints were being managed in line with the provider's procedure.

At our last inspection some people's end of life wishes had not been clearly documented. This meant we could not be sure people's wishes would be respected at the end stage of life and following their death. Records we looked at during this visit showed improvements had been made. Where people had chosen to share their wishes, these had been recorded. For example, one person's plan included information about their wish to be cremated.

Is the service well-led?

Our findings

Previously, the 'well-led' key question was rated 'Requires Improvement'. We found a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's systems to monitor the quality and safety of the service were not effective and staff did not receive the management support they needed to carry out their roles effectively and safely. At this inspection sufficient improvement had not been made in response to the breach. The rating remains unchanged.

During this inspection the chief operating officer was open and honest about the challenges the service had faced since our last inspection. The home was going through a period of instability which had been caused by further management changes, high levels of staff sickness and some staff not working in line with the provider's expectations.

We acknowledged some action had already been taken to address these issues and further action was planned. However, required improvements had not been made to demonstrate the service was well led.

On the second day of this inspection the chief operating officer explained the actions that had been taken since the last inspection, including strengthening quality monitoring arrangements. However, we found completed quality audits and checks were not yet embedded at the home and therefore not fully effective. For example, risk management issues we had found had not been identified.

In addition, some of the provider's auditing processes were not sufficiently detailed to ensure they were effective. For example, the audit tool used to check the management and administration of medicines did not include checking prescribed creams and lotions kept in people's bedrooms. This is an important aspect when auditing medicines to ensure creams and lotions are not being used outside their expiry date. We discussed this with the manager who told us, "I agree. We are looking at our audits." The chief operating officer gave assurance action was being taken to improve the management and checking of medicines.

Care planning at the service had improved in parts since our last inspection, but there continued to be gaps. For example, a plan was not in place to support staff to manage one person's behaviour.

The senior management team told us they were committed to driving forward improvement to benefit people. However, we found senior managerial oversight and communication with the home's management team required improvement. For example, we shared our concerns in relation to low staffing levels at the home with the chief operating officer. In response they told us they had received assurance from the home manager that enough staff had been on duty. Staff told us, and records confirmed, this had not been the case.

Staff felt the home was not well led. One staff member explained this was because they did not feel supported by the home's management team. They added, "Yesterday we were short (staffed). Neither the manager or deputy manager offered to help us." We discussed this with the deputy manager who told us

they had been unable to help staff because they had needed to complete staff rotas. When we shared this with the chief operating officer, they amended the deputy manager's working arrangements, so they had more time allocated to work alongside and support the staff team.

Management support within the home was not always sufficient or effective. For example, at the start of our inspection we saw the home's administrator was left to deal with immediate concerns including staffing issues. This was because neither the home manager or deputy were on duty. We discussed our findings with the chief operating officer who immediately changed the management teams working hours to ensure management support was available when people and staff needed it.

The home's management team had not ensured systems and processes to protect people from abuse were consistently followed. We found one incident had not been reported as required.

This was a continued breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Despite our findings most people and relatives felt the home was well run. Comments included, "It seems okay to me" and, "Every other week there seems to be another new manager, but I can't say it affects us. The place is run okay."

The home's previous registered manager had left their employment in August 2018. At the time of our inspection visit a new manager had been in post for three weeks. They told us they planned to begin the registered manager application process with CQC.

The new home manager explained they had been assigned a 'buddy' who was a registered manager from another of the provider's services. They told us this made them feel supported and was helping them to understand the provider's systems and processes. They also had weekly telephone calls with the chief operating officer and were being supported by the operations director whilst they settled into their new role.

Staff told us they had some opportunities to attend meetings with the management team to discuss the service and raise any issues. We saw planned meetings were scheduled to take place shortly after our visit.

The provider's PIR informed us meetings for people and their relatives took place every two months. We saw, and people told us this happened which gave people opportunities to share their ideas and suggestions to improve the service. However, one relative commented, "Often a notice goes up on the board without much consideration to time, I would like a more formal invite in a timely manner."

People and relatives were also invited to provide feedback about the service through satisfaction surveys. We saw the latest feedback had been gathered and analysed in May 2018. However, we saw low staffing levels had been raised as an issue by three relatives. It was not clear what action had been taken to address this issue and we found the number of staff on duty was lower than the number required to meet people's needs. This meant the provider had not used feedback to improve the service people received.

It is a legal requirement for the provider to display their ratings so the public are able to see these. We checked and found the home's latest CQC rating was displayed within the home and on the provider's website.

Following our inspection visits we met with the chief operating officer. They spoke of the action they had

already taken and further actions they planned to take to address the issues we had identified. The chief operating officer also confirmed their intention to restrict admissions into the home. This assured us that when new people moved into the home, their needs could be met.

After our inspection we shared our findings with the local authority and the CCG. They informed us they were continuing to closely monitor the quality and safety of the service provided to people.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not ensured care and treatment was always provided in a safe way.</p> <p>The provider had not ensured where risk had been assessed that records provided staff with the up to date and accurate detail they needed to manage and reduce risk.</p> <p>The provider had not ensured people had received their medicines as prescribed.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided.</p> <p>The provider's system of governance did not provide sufficient assessment and monitoring of risk to mitigate the risks to the health, safety and welfare of people who lived at the home and staff.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider has not ensured there were always enough staff available to keep people safe and to support people when needed.

