Castle Meadows (Dudley) Limited

Castle Meadows Care Home

Inspection report

112 Dibdale Road
Dudley
West Midlands
DY1 2RU

Tel: 01384254971

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 and 23 May 2018 and was unannounced. The home was previously owned by a different provider and this was the first inspection of the service under the new provider registration.

Castle Meadows 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.

Castle Meadows Care Home provides accommodation, personal and nursing care for up to 51 people who may be living with dementia or a physical disability. At the time of our inspection there were 31 people living at the home. The home is divided into two units; the residential unit and the nursing unit but due to refurbishment people were accommodated in one unit at the time of inspection.

There was 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.

This inspection was brought forward because we received some concerns about the service and we wanted to make sure people were receiving safe care. The concerns related to staffing levels during the night and staffing levels on the first-floor unit. During this inspection we found no evidence of poor staffing levels although occupancy numbers were low. We identified that the deployment of staff should be monitored to ensure people on the first floor receive consistent care. We saw the provider was taking action to ensure there were sufficient nursing staff available at night to include sourcing agency nurses when needed.

The provider was not meeting the requirements of the law in relation to managing people's medicines. People were not always protected against the risks associated with the unsafe use and management of medicines and some people had not received their medicines as prescribed. The provider was unable to demonstrate that people were having their medicines administered safely.

Staff knew how to recognise signs of abuse or harm and how to report this and were aware of how to manage risks to keep people safe. The provider practiced safe recruitment with the required checks carried out before staff started work. There were processes in place to manage the prevention and control of infection. The registered manager reviewed accidents and falls to ensure people had the right support to keep them safe.

People were supported by staff who had received relevant training. People told us they enjoyed the meals and we saw staff offered people hot and cold drinks throughout the day. People were supported to access health professionals when they needed. Staff supported people to have maximum choice and control of their lives in the least restrictive way possible; the policies and systems in the service support this practice.

The provider was improving the premises and facilities to ensure they were suitable to meet the needs of the people who used the service.

People were complimentary about the caring approach of staff. They said they were kind and considerate. We observed caring and friendly relationships between people and staff and heard examples of where staff had been particularly thoughtful. People said they were supported to express their views about the care they received. Whilst staff showed respect for people and the need to promote and protect their privacy and dignity there were occasions where this lapsed.

People were involved in planning their care and staff responded to people without delay. Care plans were being improved to reflect people's chosen routines. People said they enjoyed the social and recreational opportunities available to them. There was clear system in place to manage complaints which were investigated and responded to.

Staff reported that leadership was more consistent under the registered manager and the new provider. There were systems in place to monitor the quality of the service. However these were not fully effective in monitoring and improving the quality of care to people. People had the opportunity to feedback on the quality of the service. There were links with other agencies to gain advice and share best practice to improve the quality of care to people.

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?

Requires Improvement

The service was not safe.

People's medicines were not managed or administered in a safe way.

People were supported by staff who knew how to recognise and report concerns and manage risks to their safety.

The registered manager was aware of concerns around staffing levels and had taken action to address this. Staff had been recruited safely.
Infection control procedures were in place and followed by staff.

Is the service effective?

Good

The service was effective.

People's needs were assessed and they were supported by staff who received appropriate training. A plan was in place to improve the consistency of staff supervision.

People enjoyed their meals, had access to regular drinks and their nutritional needs were met.

Health care professionals were accessed for support.

Improvements to the design and decoration of the premises met people's needs.

Staff understood and protected people's human rights in line with the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and considerate in their approach.

People's communication needs were met by staff and people were supported to express their views about their care.

People's privacy and dignity was understood but not always promoted.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning and review of their care and supported to take part in a range of activities.

People were confident any concerns or complaints would be addressed.

There were processes in place to ensure people would receive appropriate care at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems were in place to monitor the quality of the service but these were not fully effective.

The new provider engaged with staff to promote a positive culture.

The provider had worked with other agencies to improve outcomes for people and people's views on the service were sought.

Castle Meadows 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.

The inspection was prompted in part by concerns shared with us about staffing levels. We looked at this during the inspection.

The inspection took place on 22 and 23 May 2018 and was unannounced. The inspection was completed by one inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback. This was the provider's first inspection since they registered with us, the Care Quality Commission, in February 2018 and therefore as the inspection was brought forward they had not been requested 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 into account that when we last inspected this service under the previous provider that there were two breaches of regulations related to providing safe care and treatment. Although the provider had since changed, the registered manager and staff team were the same and we therefore checked what progress had been made to ensure people received safe care.

We spoke with 14 people who lived at the home and two relatives. We spent time with people in the communal areas of the home and used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of those people who cannot tell us about the service. We sampled five people's care plans and records to see how their care was planned and delivered. In addition we looked at 12 people's medicine records, observed a medicine round and checked the storage

and temperature of medicines. We spoke with seven care staff, the cook, a domestic, a nurse, the registered manager, provider and nominated individual. We also spoke with a visiting healthcare professional. We looked at two staff recruitment files, staff training records, accidents/incidents and safeguarding records, menus and the provider's quality monitoring and audit systems.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed and found the administration records showed some discrepancies between them and the quantity of medicines found. This indicated that some people had not received their medicines correctly. For example, the records showed that one inhaler containing 124 doses had been opened at the start of the current medicines cycle and the records showed that 34 doses were administered. We therefore expected to find 90 doses remaining in the inhaler however we found 102.

We also found one person had received a double dose of a medicine because the provider was administering from one box that had been supplied by the GP and from another box that had been supplied by the hospital. We spoke with the person concerned and they were able to describe experiencing some of the recognised side effects for this medicine. We discussed our concerns with the registered manager who contacted the GP for advice and raised a safeguarding alert regarding the overdose to the local authority.

Some medicines that had been prescribed on a 'when required' basis did not have effective written information to support staff on when and how these medicines should be administered. A number of people had been prescribed a sedative medicine on a 'when required' basis to treat their anxiety and aggression. When these medicines had been administered we found little or no written evidence that demonstrated the need for their administration. Staff were not able to describe the circumstances in which this medicine would be given. The provider was therefore unable to demonstrate that these sedative medicines were being administered appropriately.

The provider was not monitoring the maximum and minimum temperatures of the medicines refrigerator on a daily basis and therefore the provider was unable to demonstrate those medicines stored in the refrigerator were being stored safely. Temperature sensitive medicines called insulin were stored in this refrigerator. Not knowing whether the refrigerator had been maintained between two and eight degrees Celsius the provider was advised by our pharmacist to obtain new supplies of the insulin and discard the current stock.

Where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely.

Nurses were not recording the location of where pain relief patches were being applied to people's bodies. We spoke with a nurse who confirmed the rotation of the patches was not following the manufacturer's guidelines and therefore these patches were not being applied safely and could result in unnecessary side effects.

This demonstrated a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us they felt safe living at the home and with staff. One person told us, "I feel quite safe; staff keep

an eye on me". A relative told us they had no concerns about the safety of their family member. Staff had received training in how to safeguard people from harm or abuse and were aware of signs which may indicate that someone was being harmed and how to report any concerns about people's safety. One member of staff told us, "Any concerns we have we report to the nurses or manager; if someone has been hurt or has bruising it would be reported to the local authority". The information we held about the home showed that the registered manager had made referrals to the local authority safeguarding team and Care Quality Commission appropriately when any concerns were identified.

People told us they were happy with the way staff helped them to keep safe. One person said, "They use the stand aid to help me to get to my feet; I feel quite safe with staff". A visitor told us; "I see staff helping people every day; they take their time and are gentle, I have no worries there". Staff we spoke with understood the risks to people's safety and how these should be managed. We saw risk assessments were in place to guide staff in how to support people. For example, people at risk of falling had plans which identified their equipment, and staffing levels to keep them safe when mobilising or being moved. We saw staff assisted people safely when using equipment such as hoists and stand aids. Risks related to choking were identified to ensure people had food and drink that they could swallow safely. We saw staff ensured people were in an upright position to further reduce risks. Monitoring records showed that where people were at risk of developing pressure sores their position had been changed at regular intervals to reduce risks. Staff were well informed about the changing risks to people's safety and told us these were communicated during handover so that risks were managed in a consistent way.

Our information showed that concerns had been expressed about staffing levels on the first floor where people had been observed to be left unsupervised for periods of time. Concerns about night staffing numbers had also been shared with us. The local authority advised us they had visited and reviewed staffing levels. We spoke with the registered manager and saw that they were aware of the concerns around staffing levels and had taken action to address this. They had increased early morning staff to assist at peak times and had used agency nurses to cover nurse absence. We were told a dependency tool was used to calculate staffing levels and that staffing levels would be reviewed as occupancy levels increased. During our visit people told us that there was enough staff to support them during the day and night and that when they used their call bells they did not have to wait too long for a response. One person told us, "They generally come quite quick; I've got no complaints". Another person said, "Well they are busy but they do come when you need them". Staff told us that they thought staffing levels were safe, more consistent and that the deployment of staff had improved. Our observations showed that there were sufficient numbers of staff available to support people and people were being responded to in a timely way. We saw that staff were visible on the first floor and they told us the expectation was that the lounge area was always supervised.

The provider had ensured that recruitment processes were followed to ensure that the required checks on new staff were sought. Records showed that a Disclosure and Barring Service Check (DBS) which provides information about any criminal records, was undertaken. We found that references were in place as well as work history and checks with the Nursing and Midwifery Council (NMC), were made prior to new staff starting work to ensure they were safe to practice.

People told us that the home was always clean and smelled nice. We saw that staff followed infection control procedures by wearing PPE (Personal Protective Equipment) such as gloves and aprons. Domestic staff told us they had cleaning schedules which included checking inside mattress covers for any contamination. Procedures for handling soiled clothes or collecting clinical waste were followed correctly by staff. The home was clean and there was a team of staff available to ensure cleanliness standards were maintained.

The registered manager had learned from incidents that had occurred at the home and had taken action to keep people safe and reduce repeated occurrences. Under the previous provider at our last inspection in April 2017 there were breaches of regulations because people did not always receive safe care and staff did not use the provider's processes for reporting neglect. At this inspection under a new registered manager we saw they had ensured that the provider's systems for safeguarding people were operated effectively. They had recognised and escalated concerns relating to unsafe care and taken action to reduce harm.

Good

Is the service effective?

Our findings

People told us that they had been involved in an assessment of their needs before they came to live at the home. A person told us, "Someone came to see me before moving in and asked me about my health, what help I needed and what I liked".

Records we looked at confirmed that people had been involved in the initial assessment of their needs and information about people's care needs, medical history and their preferences had been sought. This included taking account of the diverse needs of people when assessing and planning their care such as their disability. For example we saw plans were in place to support people at risk of falling and ensure assistive technology such as a sensor alarms to monitor people's movements were in place. Some people required support with their mobility and we saw they had walking aids and hoist equipment in place to support their needs and help staff to deliver effective care. People told us they had been asked about their religion and whether they wished to worship; a service was conducted in the home for people to attend. Another person told us, "I was asked if I had any objections to male or female staff assisting me to be honest I don't". These processes help to ensure there was no discrimination in relation to protected characteristics under the Equality Act when making care and support decisions about people's care.

Staff had an induction before starting work which included completing training and shadowing experienced staff. Staff we spoke with spoke positively about the induction and felt this equipped them with the skills they needed to support people. One member of staff told us, "I shadowed other staff so I felt confident to work on my own and I did training so I could meet people's needs, like hoisting them safely".

Records confirmed that staff had completed training to ensure they supported people effectively. This included training specific to people's individual needs such as dementia awareness. Nurses told us training in specific nursing tasks had also been undertaken so that they could care for people at the end stage of their life. We found that medicine management was not safe; the impact of this was evidenced via the concerns we identified in relation to medicine management. This was discussed with the registered manager who informed us that all the nurses and senior staff would be undertaking additional re-training including medicine management to ensure the expectations and competencies were clear.

The registered manager was aware that staff supervisions were behind schedule but had taken action to address this with a planned schedule in place to ensure staff had regular support. Staff told us however that they felt supported because they could speak to senior staff or nurses about any issues with their practice. One staff said, "I feel I can speak openly; senior staff and nurses will also advise us about our practice such as manual handling or whether we are interacting with people".

We observed that systems were in place to ensure that where people had wounds, the frequency of dressing routines had been identified and followed to ensure people had effective clinical care. We saw that staff assisted people throughout the day with a variety of equipment such as stand aids and hoist equipment and applied their manual handling training correctly to ensure they supported people safely.

People spoke positively about the quality and variety of meals. One person said, "I think it has got better lately; the meals are nice and there's always a choice". Other people told us they could have a cooked breakfast of their choosing and that food and snacks were available throughout the evening. We observed staff were attentive when assisting people with their meals and people had appropriate utensils and cutlery to enable them to eat independently. People were assisted to make choices by staff showing them a choice between two plated meals. Meals were served on specific coloured plates as there is evidence that for people living with dementia this helps them to identify their food more easily. Nutritional assessments identified those people at risk of not eating enough or at risk of choking. Staff followed the recommendations from the Speech and Language Team (SALT) to ensure people had their food presented at the correct consistency. The cook was well informed about people's specific dietary needs and we saw these were catered for. A choice of drinks was also available to people throughout the day and we saw staff regularly top up people's drinks and support them to drink. Monitoring charts were consistently filled in to ensure a record of people's fluid intake was available to help identify people at risk of dehydration.

People's individual needs were met by the adaptation of the premises; a lift enabled people to access the first floor, and handrails were available throughout to support people's mobility. Adapted bathrooms and toilet areas ensured people could use facilities safely. Garden space at the rear of the premises was level and accessible to people who we saw enjoyed sitting out. The new provider was refurbishing the nursing unit to improve the dining area. At the time of inspection signage was removed from some parts of the home due to decoration, but people told us they could find their way around the home. The use of contrasting colours would support people living with a diagnosis of dementia to orientate themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. They had received training in MCA and could identify where people gave consent with gestures or body language. One staff member said, "Some people consent by taking your hand, smiling or nodding; other people may refuse; push you away, but we would know when someone is consenting". We saw people made their own decisions in relation to what they wore, what they ate and drank and how and where they spent their time. We saw staff sought people's consent before assisting them with care tasks which helped to ensure people had control over their care. Best interest decisions had been taken to ensure some people's safety and well-being.

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 procedure for this is called the Deprivation of Liberty Safeguards (DoLS). We checked and saw that staff were working within the principles of the MCA. DoLS applications had been sent to the local authority and staff understood who these restrictions applied to. DoLS authorisations were in care files as guidance for staff to follow. This information was not reflected in people's care plans which would enhance the information and guidance for staff to follow.

There was effective liaison with other organisations and teams so that people received support from healthcare professionals such as GP's, palliative care teams, district nurses and chiropodists. A visiting healthcare professional informed us that communication between them and the service was good and kept them informed of changes to people's health. Records contained information about consultations and advice provided to staff to support people. Staff we spoke with understood people's health needs and how they escalated these to ensure people had timely access to professionals. We observed a 'flash meeting' which took place daily to identify any immediate concerns and actions needed. Staff told us communication

was good and they were kept informed of changes to people's needs.

Good

Is the service caring?

Our findings

People told us that they were treated with kindness and compassion. We observed many examples of staff demonstrating a caring and compassionate approach towards people. One person told us how staff had been out shopping for them as they prepared to return to their own home following a short stay in the home. They said, "She [staff] was so kind I was very worried as I had no food in, she was so kind and did a big shop and has left it for me at my house".

People felt that they mattered because staff were attentive and caring towards them. We saw examples of a caring approach when staff were supporting people in distress and making people comfortable by assisting them with additional clothing an extra cushion or drink. In addition we saw staff regularly interacted with people and spent time chatting with them; in response we saw people were happy; smiling and chatting back.

People's care plans provided guidance about the support people needed with communication. We saw staff understood how to communicate with people such as providing explanations to aid people's understanding. Staff were aware of people who needed support with accessing information, for example a person had been provided with a magnifying glass to read articles. We observed staff checked that people had their hearing aids and glasses on which supported their access to information. We saw staff were aware of a person who used gestures and hand signals and were able to translate the person's requests. This approach helped people who had limited communication skills and or dementia to communicate their needs.

We found from our discussions with staff that they referred to people in a respectful and affectionate manner. Staff displayed a genuine interest in people's well-being and a commitment to providing affection as well as care. One person told us, "I had flu rather badly about a month ago; the carers have been wonderful and have nursed me back to health". A staff member told us, "We are genuinely committed to looking after people".

Staff understood people's personal histories, were knowledgeable about the care people needed and respected their preferences. This gave people confidence in the care they received, for example one person told us, "I don't think I would like to be at home now. I am very settled". A person told us if they were awake they sometimes liked to get up early. Staff checked with them every morning but if they were asleep they did not disturb them. Another person explained how staff supported them with their mobility, they said, "I feel they [staff] know me quite well now, we can have a laugh and they all work so hard and treat me with respect". Our observations showed staff knew people well and we saw they regularly engaged people in conversation and took an interest in them. For example we saw staff regularly engaged with a person about their hobbies; knitting and flower arranging. We also heard staff discussing with people the recent royal wedding which they had all celebrated. During a clothes show we saw staff supporting people with choosing their clothes styles which indicated they knew what people liked to wear.

We saw that staff showed concern for people's wellbeing in a caring and meaningful way by attending to

people's comfort needs and spending time with them when they were upset. One person told us, "When they come to my room they always take the time to have a chat with me; makes me feel good". We observed positive relations between people and staff who were attentive and anticipated when people needed assistance or comfort. A relative told us that staff, "Staff always put mom's welfare first and look after her really well".

We saw staff encouraged people to express their views and they were actively involved in making decisions about their care. We saw people decided what time they came down to the lounge and what they had at mealtimes. We saw people could return to their bedrooms to rest when they wanted to. One person told us, "I like to go to my room in the afternoon; they know my routine and will take me". People told us and we saw that people had opportunities to talk with the registered manager or staff about their day or how they were feeling. One person told us, "I can speak to anyone about my care; they are all lovely and listen to me". Relatives told us they were involved in their family member's care. One relative told us, "I have been involved in care plan reviews and I can talk to the manager if there are any issues". Information about advocacy services was available should people need support with expressing their views about their care.

People told us that staff supported them to maintain their independence. We observed staff were encouraging and prompted people to use their walking aids or encouraged them to independently eat their meals. Staff informed us that they always prompted people to carry out some aspects of their personal care themselves. We saw from care plans that staff had guidance as to the level of support people needed and their preferences about their care.

People told us they maintained relationships with their friends and families and we saw visitors were able to visit at any reasonable time. Relatives told us they were made welcome and had positive relationships with staff; some relatives actively supported the home via voluntary work within the home.

People told us that staff protected their privacy and dignity. One person told us, "When staff assist me they do so in the privacy of my room or the toilet". Another person said, "They [staff] are very good; always knock the door and keep me covered when helping me wash or dress". We observed that staff were discrete when offering personal care. We saw they maintained people's dignity by ensuring people's clothes were protected at mealtimes and they were assisted to change clothing as needed. However we did observe occasions where people's dignity was compromised. For example people were not offered privacy screens or the option to return to their bedroom when receiving treatment from visiting health professionals. The health professional confirmed she was not offered the option of screening for people and the people concerned confirmed they usually had their treatment in this manner. This meant that people's privacy and dignity was not always respected. We discussed this with the registered manager who advised us they would ensure that privacy screens or a return to people's bedrooms was offered to protect people's dignity.

Good

Is the service responsive?

Our findings

People told us that they had been involved in planning their care. They were involved in the initial assessment and in discussions to plan their care to include important information about their history and personal preferences. People also told us they were regularly asked if their care routines were still suitable to them. One person said, "They will change things around to suit me, like having a bath, or the time I get up which is nice". Records we looked at confirmed that information about people's care needs, medical history and their preferences had been sought from them and their family member.

People's communication needs had been explored as part of their initial assessment in terms of the support needed to access information. This ensured that care planning took into account people's needs such as sensory disability or dementia so that people could receive appropriate care centred on them. For example where a person with a sensory loss refused to use their hearing aid their plan reminded staff to provide clear instructions when speaking with them so that they could understand information more easily. We saw examples of how staff had provided support to meet the diverse needs of people using the service including those related to physical disability or dementia. Where people required the use of equipment to support their mobility we saw this was in place and encouraged by staff. We saw that staff ensured people could access their buzzer to call for assistance from their bedrooms or staff conducted regular checks on people where they were unable to use their buzzer. Assistive technology such as sensor alarms were in place where people were at risk of falling in their bedrooms; this ensured staff could respond to people's movements to assist them. This approach helped to ensure that people received personalised care that was responsive to their needs.

Care plans contained some personalised information to support staff in how to deliver people's care. For example staff knew about a person's declining appetite and the care plan had been updated to reflect the support the person needed. Another person at risk of falls was being supported with additional assistance in line with their care plan to help reduce falls. They told us, "The staff help me to walk and I use a walking aid now". A person who occasionally refused personal care had a plan in place which identified how staff should encourage and monitor their personal care and appearance. Staff we spoke with were able to describe the approach they used to support the person which showed their knowledge of the person and helped to ensure they received the care they needed. The registered manager informed us that they were in the process of changing their care plan format to ensure more personalised information to guide staff about people's care. We observed that people's personal care routines were carried out to ensure they had the support needed with their appearance and that this information was identified in their care plan.

People's preferences about their daily routines such as the time they wished to get up or go to bed were responded to. People told us that staff knew them well; one person said, "They know I am a bit loud and rude but it's all banter and they take it well". We observed that staff engaged with this person, knew a lot about their previous history and were able to talk to the person about things that were important to them such as their childhood and what that felt like for them. Staff had training in equality and diversity and showed awareness of respecting people's religion, culture and sexual orientation. Staff told us people's decisions about how they live their lives would be personal to them, kept confidential and respected.

People told us they had been involved in the review of their care plan. One person said, "We do have meetings now and again and I think they have been making care plans recently". The registered manager informed us they were updating care plans to ensure personal preferences were reflected and that the information was accurate. A relative we spoke with confirmed they were updated with changes and involved in care reviews. The relative told us, "I've attended reviews and meetings to discuss mom's care; the staff are good at keeping me up to date if she's having a bad day".

Staff told us they had handovers at each shift which kept them updated with changes to people's care needs. We saw for example that where people needed their position changed or they were not eating or drinking, this was shared with staff to help them respond to people's needs. A staff member said, "Any changes or risks such as a person falling or not being well, we are told about and then we know what we need to do to support them that day". We saw that such changes were communicated to senior staff and nurses to ensure escalation of concerns were acted upon. For example calling the doctor out or updating the risk assessment to reflect changes and guide staff. This helped to ensure staff could respond to people's changing needs without delay.

People were supported to follow their recreational interests and we saw this was encouraged. A few people enjoyed knitting squares and sewing them together to make blankets. A person also told us about the flower arranging that she was encouraged to do as she had specific skills in this area and we saw her arrangements on display. Other people told us they had been involved in gardening. We heard from people that a range of indoor activities took place to include craft, board games, keep fit, quizzes and movement to music. Planned trips out to places of interest were organised so that people could access places they wished to see. One person told us, "I go out on day trips sometimes, there is the ring and ride and a few of us go out for the day, we have been to the Black Country Museum, to Stratford on Avon, Boughton-on-the-Water and the Birmingham museum". Another person said, "When the weather is good we go and sit outside, and chat, carers come to. We have strawberries and ice cream sometimes too". We saw a clothes show take place and people told us this was also a regular event. We were informed that plans were in place to extend the activities and materials needed to support people with dementia, such as rummage boxes and sensory objects. There was a dedicated activities coordinator and people told us they were asked what they would like to do or where they would like to go and that transport was provided to assist them to do this.

People told us they were happy living at the care home and could speak to someone if they were dissatisfied with the care they received. One person said, "I haven't had the need to complain; staff try hard and do a good job, food's good and I'm okay". Other people told us they would speak with their family, staff or the registered manager and were confident they would be listened to. Details of the complaints procedure were available in reception. Records of complaints showed these had been investigated and the outcome fed back to people in writing.

The provider had ensured that nurses and staff had appropriate training and advice from palliative care teams to respond to the people who were in need of end of life care. This ensured that people would have prompt access to equipment and other health professionals in the last days of their lives. We saw that nurses had the skills to manage anticipatory medicines that had to be administered in a specific way to support people with their pain. End of life care plans included information about pain management and the comfort needs for people. We also saw staff were aware of people's wishes, for example one person had requested staff sit with them and this was happening for that person. We saw that staff conducted regular checks on people as they were aware people's conditions could change rapidly.

Requires Improvement

Is the service well-led?

Our findings

This was the first inspection of this home under the new provider who registered with the Care Quality Commission [CQC] in February 2018. There was a registered manager in place who had had worked at the service since October 2017. She was familiar with the previous inspection ratings and the breaches in regulations under the previous provider and had taken action to address those shortfalls.

Prior to this inspection concerns were shared with us regarding staffing levels. At this inspection we saw the deployment of staff had improved. We saw that staff were visible on the first floor but as these issues had been raised previously this indicated that staffing/deployment was not as consistent as it should be. Whilst the registered manager told us they reviewed staffing numbers, there was no information to show how they monitored the deployment of staff on this floor to ensure it was consistent.

The registered manager had systems in place to monitor the quality of the service people received. This had led to some improvements in terms of care planning. She was reviewing care plans to introduce the new provider's format so that plans were more personal to the people using the service, this work was not yet completed. We saw that a system was in place to ensure clinical care tasks were completed in line with people's needs. The provider's checks included reviews of equipment and maintenance of the home environment such as fire safety and infection control. Competency checks and additional training in manual handling techniques had helped to ensure that staff applied their training to their practice so that people were moved safely. However, the provider's audits were not fully effective in relation to identifying concerns in relation to medicine management that we identified at this inspection. We also identified that people's dignity was at times compromised .

People who used the service said they were happy with the way it was run and that the registered manager frequently spoke with them to find out how they were. One person told us, "The manager comes round every day, she stops for a chat, and I would tell her if I had any problems". Relatives told us they liked the atmosphere in the home, it was welcoming and they could approach the registered manager with any issues.

Staff acknowledged that leadership was becoming more consistent; they described improved communication via the 'Flash meetings' held daily to identify immediate risks and changes to people's needs. We found there was some room for development in terms of relationships and expectations. Some staff described other staff as 'resistant to change and stuck in their old ways'. Our discussions with the registered manager identified that whilst she has an agenda for improvement there have been some difficulties promoting this. The registered manager was trying to support staff to evolve and develop their practice and recognised this was a period of transition.

A staff survey recently carried out identified levels of dissatisfaction with low morale and staff feeling deflated. The registered manager believed staff provided a good quality of care but wanted to improve stability for staff. They recognised constant changes had made it difficult for staff to have confidence in the service. A common feature of staff feedback was they did not always feel they were appreciated for the work

they did, one member of staff said, "I feel we don't get any thanks or recognition for the hard work we do, it would be nice to feel appreciated". We saw that platforms for staff to discuss issues such as staff meetings had recently been disrupted due to the change in provider; in addition, staff supervisions were not all up to date although the registered manager had a plan to address this. Improved communication would ensure staff were subscribing to the manager's vision and have a better understanding of expectations. However staff identified positive features such as teamwork. One staff member said, "Team work here is really good; I feel supported by colleagues and love it here".

There was a management structure in place and the registered manager was being supported by a regional manager and the provider both who visited regularly. Staff reported that they were gaining in confidence in terms of the new provider's improvements to the service in upgrading the environment and improving the menus and flexibility in purchasing food supplies. They described the provider as, 'hands on' and that both he and the regional manager were 'easy to talk to'. Staff were excited about the improvements being made to the homes environment.

The registered manager informed us that new policies and procedures were in place since the new provider took over but she had not yet had time to familiarise herself with these. We saw that systems to identify and escalate risks to the quality of the service were in place. The registered manager completed a weekly report that reviewed areas such as staffing levels/accidents/ complaints or safeguarding incidents. We saw that where accidents had occurred a root cause analysis was undertaken with actions for improvement identified to ensure that the required improvements could be made.

Where incidents had occurred at the service, the manager had notified us of these as required. The staff were all aware of how to raise concerns and could explain the whistleblowing process. One member of staff told us, "We covered whistle blowing in our training".

People's feedback was sought with the aim of improving the quality of the service they received. The provider had carried out a survey but the results of this had not yet been analysed or action identified.

We saw the provider had held a relatives and residents meeting in which to address any concerns about the changes taking place in the home. We saw new proposals were shared with people in relation to routines within the home, care planning and protected mealtimes. People had raised individual issues and we saw action had been taken to address these, for example a person's mattress was replaced and another person's request for items in their room addressed.

The registered manager told us they shared the same vision as the provider for the future of the service. This was to establish good quality care to people within an environment that was designed to meet their specific needs. We saw that in order to improve the quality of people's lives at the home the provider was undertaking major refurbishment work to include complete redecoration of the dining area. This would provide improved facilities in which people could socialise and eat their meals comfortably.

The registered manager had established links with other agencies to gain support or share best practice to ensure the quality of care and support was continually improved. We saw they had recently worked with the local authority to review the quality of the care people received and staffing arrangements. The local authority told us they had identified the need for personalised care plans and improved staffing on the first floor. The provider had linked with the local hospice to source training for nurses in relation to end of life care. Nurses told us this training and joint working would help to promote and raise the level of end of life care to people when this was needed. The provider had also sourced additional safe medicines training with the Clinical Commissioning Group (CCG) to ensure nurses and senior staff were fully skilled. The provider

has been responsive to managing immediate concerns regarding a major leak at the home which had warranted major refurbishment work.

As this is the first inspection for this provider they will be required to display the Care Quality Commission rating following this inspection.

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 People who use services were not protected by the proper and safe management of medicines. Regulation 12 (1) (g).