HC-One Oval Limited

Priory Mews Care Home

Inspection report

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Date of inspection visit:
06 November 2017
07 November 2017

Date of publication:
10 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 5 and 6 November 2017.

Priory Mews Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service comprises of five separate units adjacent to each other. Beaumont and Berkeley provide residential and nursing care for 30 and 15 people respectively; Marchall and Mountenay provide care for people with nursing dementia needs for 23 and 30 people respectively; and for Cressenor House cares for 42 people with residential dementia requirements. A separate house accommodates the main reception, the kitchen, the senior management team, and the administration team. There were 137 people living in Priory Mews at the time of our visit.

The service was run by a registered manager and they were present on the days of our visit. 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 is the first time the service has been rated Requires Improvement.

People and their relatives told us staff were kind and caring and made people feel safe. They said staff had the necessary skills to respond to people's needs, monitored their health and that people enjoyed their meals. However, we found inconsistency in care practices across the service which meant that people did not always receive the level of care expected.

Systems to monitor the quality of care were not effective. Staff did not always follow guidance or escalate concerns in relation to potential risks to keep people safe. Accidents and incidents were not suitably monitored to make sure that actions taken were effective. Records were not always accurate or accessible which could result in them receiving inappropriate staff support.

Staff who administered medicines had been trained in how to do so, but there were not safe systems in place for the management of medicines.

There was inconsistency in staff practice which meant that people's dignity was not always respected and people were not always given the support they required at mealtimes.

We have made recommendations about the deployment of staff to ensure they are available in suitable number; and infection control practices; the design of the service to meet the needs of people living with dementia and the activity programme.

Health and safety checks were effective in ensuring that the environment was safe and that equipment was in good working order. Recruitment practices were robust in ensuring only suitable staff were employed at the service.

People's health needs were assessed and monitored and the service worked in partnership with healthcare professionals to ensure people received appropriate care and treatment.

Shortfalls had been identified in staff training and plans were in place to ensure they received relevant training for their role. Staff felt well supported both informally and through formal processes such as staff meetings and supervisions.

Staff sought and received people's consent to the support they provided and in line with the principles of the Mental Capacity Act 2005. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The service had made DoLS applications, to ensure that people were only deprived of their liberty, when it had been assessed as lawful to do so.

People's needs were assessed and a plan of care was developed which included their choices and preferences. Guidance was in place for staff to follow to meet people's needs.

The views of people and their relatives were sought through meetings and an annual survey.

We found four 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 this 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 always safe.

The management of medicines did not always ensure that people received their medicines as prescribed by their doctor.

There were not effective systems to ensure the service learned and made improvements from significant events.

Potential risks to people's health and welfare were not always acted on, or guidance in place followed to ensure people's safety.

Checks were in place so only suitable staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutrition was monitored but they did not always receive the support they required at mealtimes.

The design and layout of the service did not always take into consideration the needs of people living with dementia.

Staff felt well supported and the service was working towards ensuring staff had the skills and knowledge they required for their role.

People gave consent to care and support. Staff supported people in line with the principles of the Mental Capacity Act 2005 and the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff had built positive and caring relationships with people but this was not consistent throughout the service.

People were not always treated respectfully or supported in a way that was caring and upheld their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's needs were assessed and support plans gave guidance to staff about how to provide their care.

There were inconsistencies in people's experiences of being offered meaningful activities.

People and their relatives knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of strategic oversight which resulted in people receiving inconsistencies in the quality of care provided.

Quality assurance systems were not always effective in highlighting areas where improvement was needed.

Records did not always accurately reflect people's care and treatment and were not all easily accessible.

The views of people and relatives were sought and acted on.

Priory Mews 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 checked 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 service had previously been registered with the provider, Bupa, under a different legal entity. This was the first inspection after the change in registration on 31 January 2017 and was carried out to check that the service was safe, effective, caring, responsive and well led.

This inspection took place on 6 and 7 November 2017 and was unannounced. The inspection team consisted of three inspectors, two medicines inspectors, a specialist nurse advisor and two experts by experience. An expert by experience is a person who has personal experience of using similar services or caring for family members.

Prior to the inspection we looked at notifications about important events that had taken place at the service. We did not ask the provider to complete a Provider Information Return. This is information we required 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.

The inspection was informed by feedback from nine people and eleven relatives. We observed lunchtime in each unit and also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also obtained feedback from a number of professionals including two district nurses, a care manager and a commissioner and safeguarding lead from the local authority.

We spoke to the registered manager, operations manager, receptionist, four nurses, 12 care staff, the activities manager and one activity coordinator and the catering manager. We viewed a number of records including 21 people's care plans; the obtaining, recording, handling, storing, security and disposal of medicines; ten staff files; staff training records; health and safety records; and quality and monitoring audits.

At the inspection, we asked the provider to send us information on diabetes management, the assessment of staffing levels and learning from specific events by 10 November 2017. This was because it was not readily available at the visit due to computer issues. The provider informed us there would be a delay in receiving this information as technical issues continued and we received this information on 15 November 2017.

Requires Improvement

Is the service safe?

Our findings

People and their relatives all told us that they felt safe at the service. They said that they felt reassured as there was consistency in staffing and staff knew them and their relative well. Comments from relatives included, "Oh yes, definitely safe. If my relative was not safe, she wouldn't be here"; "My relative is very safe because they look after him really well"; and "She is safe as there is that feeling that staff are aware of what's going on". Feedback was that although at specific times staff were busy, there were usually sufficient staff around to meet people's needs. People and their relatives told us staff were usually quick to respond when people used their call bells.

Relatives told us that some people could present behaviours that challenged themselves or others. They said staff were skilled in managing these situations. One relative told us, "Staff are so good with my family member who can be pretty challenging at times. They approach her in a very gentle and kind way and let her respond in her own time. They often leave her and come back later which seems to work". Another relative told us, "When my relative is quite verbal, staff respond in a cheerful way. You never feel anything that is asked of staff is too much".

Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as their risk of falling, when moving around the service, of developing pressure areas, nutrition and continence. Guidance about the action staff needed to take to make sure people were protected from harm was included in the risk assessments. However, there was inconsistency in how this guidance was followed by staff and how effectively people's safety was monitored and managed.

For people at risk of developing pressure ulcers the specialist equipment they required, including airflow mattresses and cushions had been provided. There was inconsistency in the records staff completed to check this equipment was set at the required pressure to provide effective relief. Positional change records were in place which specified the frequency people should be moved and staff recorded if the person was positioned on their back, left or right side. These actions helped to make sure people's skin remained healthy. However, there were gaps in some people's records, especially between the hours of 2am and 6am which indicated they may not have been repositioned as they required.

Some people had been identified as at risk of choking and guidance was in place about how to support the person to eat and drink. It also included essential information such as if they required a soft or pureed diet and the preparation instructions for any prescribed thickening powders or liquids. One person was given a drink which was thickened according to the directions in their care plan. They were sitting at a table with another person and a member of staff. These people then left and three cups of un-thickened tea were left within their reach on the table. The person picked up one of these cups and started to drink, which resulted in them choking. Although staff responded quickly with physical assistance and giving them the correct drink to alleviate their symptoms, this incident could have been avoided.

The registered manager investigated the incident at the inspection with regards to a person choking and reported back to us after the inspection. They told us the staff member was visiting from another unit and

asked a staff member on the unit to make the person their tea as they did not know them. They stated the staff member did not drink any tea themselves and when they left the unit, the person was sitting at the table drinking their tea. The registered manager did not inform us of any lessons learned from this event, or any changes in practice to minimise its occurrence, which could have resulted in a serious harm to the person concerned.

A record was made of an accident or incident which included a description of what had occurred, any treatment given and who was informed such as the next of kin, local authority safeguarding or The Commission. Each unit reviewed these events monthly. For the service to gain an overview of significant events in the service, all forms were sent to the management team for review to see if there had been any common themes or patterns. A summary was produced which stated if events were isolated, action such as purchasing equipment or medical advice had been sought and if falls analysis had been put in place. However, the local authority informed us of two incidents when a person entered other people's rooms and placed them at risk of harm. These events had been recorded in the person's behaviour chart, but had not been reported as an incident and escalated to the management team so action could be taken to minimise their occurrence.

A 'Post Fall Assessment and Management' protocol was in place which guided staff on the action they should take if a person fell. There were different paths if the fall was unwitnessed, or if witnessed whether or not the person hit their head. Not all staff were aware of this protocol and how to put it into practice to keep people safe. One person required staff supervision when moving independently around the service with a frame and fell. Staff followed the post-falls protocol. The staff member sat on the floor with the person to ask how they were, if they were in pain, to check for any injury and advised them not to move. Staff were in the area and came to assist. Once this assessment had been completed, staff informed the person that they would get a hoist to lift them which they did. Later in the day staff told us the person had been monitored for any repercussions and we saw them sitting comfortably in a chair in the lounge. Staff told us an accident form was being completed and their care plan updated accordingly. In another person's falls diary and accident record it had been recorded they had had an unwitnessed fall. They had been assessed as having no injuries and had been hoisted to a chair. The post-falls protocol guides staff to record their vital signs and make observations ½ hourly for 2 hours and then every 4 hours in stable for a further 16 hours. There was no record in this person's care notes that these observations had taken place. The nurse on the unit told us, "We record their observations for a few hours post-fall. If they are walking then we stop". The registered manager told us the falls policy was available on all units, but this nurse told us, "I'm not aware of any falls protocol".

The provider had failed to effectively manage and respond to risks to ensure people received safe care. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their medicines as prescribed by their doctor. People were prescribed medicines to be administered at 09:00, but in one unit the medicines round did not start until 10:00. One nurse was administering medicines to 30 people and the round was not completed until 12:30. Although the nurse told us that one person needed to be administered their pain relief medicines first, most people did not receive their prescribed medicines on time. This meant that there was a risk that people would not receive the best outcome from their medicines and that the lunchtime doses could be given too soon.

Staff involved in the management of medicines received training at the start of their employment but they were assessed annually to ensure they were competent in the safe handling and administration of medicines as recommended by national medicines guidelines. Some people had not had their medicines

reviewed and some prescribed doses for people were not appropriate due to a change in their body weight. We brought this to the attention of the nurse in charge on the day of inspection, who agreed to contact the GP for a review.

Staff were not following the medicines policy in relation to monitoring stocks of medicines. Quantities of medicines received in to the service were not always recorded so the service did not have a complete audit trail of medicines and would not know if medicines went missing. One person's medicine was out of stock and could not be given which meant that they were at risk of the medicine being ineffective without regular dosing. Some medicines and dressings were not within their expiry dates and some belonged to people who no longer lived at the service and had not been disposed of appropriately. Stocks of homely remedies (medicines that can be bought over-the-counter to treat minor ailments, such as a headache) were not checked regularly and some had expired. A failure to monitor stock levels effectively could result in medicines being wasted when not used.

Staff did not always record when they applied creams to people and there were excessive amounts of creams in stock for people. This meant that the service could not be assured that all people were receiving their creams as prescribed. Staff recorded the dates of opening on liquid medicines. However, one bottle of eye drops was being used after it had been opened for longer than its expiry date of 28 days. This meant that the person was at risk of infection from bacteria as preservatives in eye drops may not be effective after 28 days.

Controlled drugs (medicines with potential for misuse, requiring special storage and closer monitoring) were not all stored in the designated cabinet in one of the units. The cabinet was too small and staff had mixed batches of some of the medicines to reduce the number of boxes having to be stored. This meant it would be difficult to check expiry dates and batch numbers of a medicine if it was recalled by the manufacturer. Staff completed weekly balance checks of controlled drugs and we found these to be correct.

Although some medicine administration sheets were printed by the community pharmacy, a large proportion was handwritten by staff and checked and signed by a second member of staff. However, some medicines prescribed on a 'when required basis' were missed during transcribing. This meant that people were at risk of not receiving their medicines when required. Guidance for 'when required' medicines was not always available. This meant that staff may not know the circumstances in which the medicine should be administered, or the signs a person might display if the medicine was needed and they were unable to ask.

Some people were administered their medicines covertly (disguised in food or drink). While appropriate assessments were completed for most people, we found that one person did not have a care plan to explain how their medicines should be given covertly. This meant that the person may not receive the best outcome from their medicines, for example if they crushed or mixed with a food that made the medicine less effective.

The provider had not ensured the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives said there were sufficient numbers of staff available. They said that there were times when staff were busy and people had to wait a bit longer for their needs to be met, but staff responded as soon as they could. The registered manager told us a specialist dependency level tool was used to assess the staffing levels required to meet the needs of people living at the service. On admission each person's needs were rated according to if they were high, medium or low so they could be adjusted accordingly. Therefore, the numbers of staff on each unit varied according to the number of people they

accommodated and their assessed needs. There were more staff on duty in the morning and these numbers reduced in the afternoon and further in the evening. The service employed bank staff to cover staff vacancies, sickness and holidays. These staff were assigned to each unit to help ensure consistency, but could also work in other units if they were required. During the inspection staff had opportunities to talk to people and responded to people's requests for assistance. However, there were some exceptions to this which indicated there were times when staff were not effectively deployed. At lunchtime in one unit sufficient staff were not available to support people who ate in the dining room as well as in their own rooms. This meant staff did not observe or respond to people's difficulties in eating independently. In the afternoon when one person asked to go to the toilet, staff responded that there was no one available to take them as staff were on a break. Due to the vacancies in activity staff, there were significant periods of time when people who found it difficult to engage in activities independently were not offered any stimulation.

We recommend that the provider seeks advice and guidance from a reputable source about the effective deployment of staff.

People and their relatives were satisfied with the cleanliness of the service. Comments from relatives included, "The cleaning staff seem to do a good job with mum's room"; "They clean every day, especially the toilets and they do a more expansive clean once a month"; and, "It is always clean here and if things get spilt and I let staff know they are quick to sort it out".

Infection control audits were carried out on each unit which included observing staff hand hygiene procedures and the cleanliness of the service. Some areas which required further cleaning had been identified and this had been followed up. The service was clean during the two days of our inspection. The exception was the dining on one unit which still had the remains of people's breakfast such as baked beans and scrambled eggs at lunchtime. Staff demonstrated they understood the action to take if they were nursing a person with an infection in order to prevent any cross infection and used personal protect equipment such as disposable gloves and aprons as a precaution. However, people did not have an individual hoist sling and these were shared between people which is contrary to national guidance. The cleaning staff worked hard to ensure there were no unpleasant odours throughout the service. A professional told us that when they visited the service it was always free from unpleasant odours.

We recommend that the provider considers current guidance on how to prevent and control infections in care homes and takes action to update their practice accordingly.

The service's safeguarding policy set out the definitions of different types of abuse, staff's responsibilities and how to report any concerns. Staff had received training in safeguarding and knew how to follow the service's policy to ensure people's safety. Staff knew how to "blow the whistle" which is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith. They felt confident if they raised a concern they would be listened to and action would be taken by the management team. However, if their concerns were not taken seriously, they said they would contact the police or Care Quality Commission.

Appropriate checks were carried out to ensure that staff recruited to the service were suitable for their role. This included obtaining a person's work references, a full employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Checks on the premises and equipment were carried out to ensure the service was safe for people and staff. This included daily walk arounds, regular servicing and visual checks of fire-fighting equipment, gas and

electricity supply, water in relation to its temperature and for legionella, window restrictors, hoists and wheelchairs. A maintenance team was employed to respond in a timely manner to any repairs needed. Each person had a personal emergency evacuation plan (PEEP). These identified the individual support and/or equipment people needed to be evacuated in the event of a fire. For example, for one person it had been identified they would not understand what to do in the event of a fire and would need one staff and a wheelchair to evacuate the building. Staff undertook fire training and fire drills which involved simulations of evacuating people which helped to give them the knowledge and skills to ensure people remained safe in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us the staff team had the skills and knowledge they required to meet their needs. They said it was reassuring that the service arranged all appointments with health care professionals so they did not have to worry about doing so. A relative told us, "I get copied into all outpatient appointments. The opticians come once a year, they can arrange the dentist and the chiropodist comes in every 12 weeks". Another relative told us, "The doctor was called in because my family member didn't look well. Some tests were done and I know the results".

People and their relatives were complimentary about the quality of food and choices available. One person told us, "I think the food is alright. If you don't like something they do their best to get what you like". Relatives said food was presented in an appetising manner and that staff encouraged people to eat. Comments included, "My relative has a pureed diet. Each food is a separate colour on their plate"; "The food is excellent. My family member doesn't always chew and has a soft diet. A staff member feeds him as he often goes to sleep at mealtimes. He loves his food and hasn't lost any weight"; and "People seem to be offered food quite often. Mum enjoys her food".

When people arrived at the service they met with a member of the catering staff to discuss their food requirements. Staff at each unit were responsible for completing a food sheet which included people's specific requirements such as if people required a soft or pureed diet and if they were vegetarian. Kitchen staff were aware of people who were diabetic, but this information was not included on the food sheets. The catering staff prepared sufficient food so people could be shown two plates of food at mealtimes and choose which one they felt like eating. The chef was passionate about their role and said they had a long standing and supportive staff team. Food was freshly prepared each day and the lunchtime meal was served so it looked appetising. The chef said that they kept some handmade frozen cakes in the freezer so that if someone arrived at the service on their birthday, it could still be celebrated appropriately.

People's experiences at mealtimes were inconsistent throughout the service. For most people mealtimes were a positive experience. People were asked what they wanted to eat and some people were shown two plates of food to help them decide. People who required support to eat were supported by a staff member who encouraged them to eat. They maintained their attention by explaining what they were going to eat, involved them in conversation and allowed them to direct the pace of their meal. Staff observed when people were struggling to eat independently and offered assistance, such as cutting up their food or replacing a fork with a spoon. Drinks were offered throughout the meal and replenished. There were effective systems in place to record and make sure that each person in the unit had been given their meal, whether they were seated in the dining room, or in their own room.

By contrast some people were not adequately supported at mealtimes. At lunchtime in one unit, staff were busy serving people in their own rooms and did not see or respond to the needs of people seated in the dining area. One person ate their dinner with their knife and another unsuccessfully tried to eat their soup with a fork. This resulted in them spilling their soup on themselves and the floor. When a person dropped their knife on the floor and kicked it around with their shoes before picking it up to reuse it, we brought this

to the attention of the staff on duty. One person fell asleep during the meal and when they awoke they were supported to eat their cold lunch. Another person left the table without attempting to eat their meal and staff did not notice their departure.

The provider had failed to make sure that people's support needs were met at mealtimes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs had been assessed before they moved to the service to check whether it could meet their needs. Assessments included aspects of people's health, social and personal care needs including their medicines, communication, nutrition, continence, skin integrity and mobility. The service made referrals and sought advice from other professionals, such as a person's GP, district nurse, speech and language therapist, tissue viability nurse and dietician when required, but these were not always followed up. A referral had been made to the tissue viability nurse for one person on 12th October, but there was no evidence in their care notes that action had been taken to ensure advice was sought from this professional.

District nurse's said they were regular visitors to the non-nursing unit of the service and had developed an effective relationship whereby there was a clear line of communication. They said they were called for advice about people's nursing needs in a timely manner and that any advice they gave was acted on. They concluded that they had no concerns about people's health needs as they were well managed. However, the local authority informed us that one person's pressure wound had not been referred to a health care professional in a timely manner and deteriorated further as a result due to incorrect treatment.

Guidance with regards to people's health needs included people's mobility, skin integrity, nutrition and hydration. A record was made of medical appointments and their outcome so that people's health needs were effectively monitored. Where people required specialist input guidance was in place to ensure the person's health needs were managed effectively. For people who had developed wounds, these were photographed at intervals and a record of progress made to evaluate any changes. A wound tracker had been introduced in each unit which recorded the number of people with wounds, the type of wound, if any professionals were involved and the current treatment.

For people with a tracheotomy there was guidance about how frequently the tube needed to be changed and cleaned and the action to take if the tube became removed from the site. A tracheotomy is a surgical procedure in which a tube is inserted to enable a person to breath. For people with a catheter staff were advised when to change and empty the bag and the signs to look out for which may indicate the person had an infection. For people with a percutaneous endoscopic gastrostomy (PEG) their plan included how the person should be positioned to be fed and the frequency and care of the PEG site and tube. PEG is a tube that feeds directly into a person's stomach.

People's needs in relation to food and fluids were assessed and the support they required was detailed in their care plan. People's weights were monitored and when there had been concerns about people losing weight, a fortified diet had been introduced to increase their nutrition. For people at risk of dehydration or malnutrition a record was kept of the person's daily food and fluid consumption. This included the food the person was offered, how much was eaten, if the food was refused and the amounts of fluid consumed. The amount of fluids a person consumed each day and their target amount was not stated on the record, but a senior member of staff had checked the amounts to indicate the person had drunk sufficiently.

People living with dementia benefit from an environment which has signage, memory aids and tactile features to help orientate and stimulate them. These needs had not always been taken into consideration in the adaption of the environment. There was a lack of information to help orientate people to the date and

structure of the day. The menu and activity timetable were written in words rather than pictures or photographs and so only some people may understand its content. There was signage to orientate people to bathrooms and toilets and some people had memory boxes or a photograph outside their bedroom, but these were not consistently displayed throughout each unit. Improvements were being made on some units by painting corridors a different colour to distinguish them, adding distinctive wall freezes and people and their family members were being consulted about choosing a colour for their bedroom door. Activities to stimulate people such as books, arts and crafts, soft toys and games were available in an activity section in the lounge, but during the inspection they were only in use if an activity coordinator was based on the unit. For people who liked to walk during the day, they were able to do so due to each unit being on the ground floor and the design of the corridors. For people with mobility difficulties, equipment was in place so people could use bathrooms and toilets.

We recommend that the provider seeks advice and guidance on adapting the environment for the needs of the people living with dementia.

New staff completed an in-house induction which included reading policies and procedures, shadowing senior staff, understanding responsibilities and undertaking training essential to their role. Staff said this gave them the skills and knowledge they required to support people. Training dates to refresh staff in key areas were provided by the area trainer and the service was responsible for ensuring staff booked onto this training when it was available. The training record for the service was held and updated centrally and indicated that a number of staff were overdue for training in infection control, moving and handling, safeguarding, mental capacity and health and safety. Training dates had been booked for staff in these areas for November and December 2017. Moving and handling training was provided by a member of staff who was a train the trainer in this area. All staff completed basic training to support people living with dementia and an enhanced course was also provided called, "Person first, dementia second". Staff who had completed this course told us it had been extremely beneficial resulting in changes in their practice and a better understanding of what it was like to live with dementia. Specialist courses were also provided in nutrition and hydration, pressure ulcers and monitoring weight loss. The nursing team were being supported through the revalidation process with the Nursing and Midwifery Council (NMC). The NMC sets standards of education, training and performance so that nurses can deliver high quality healthcare.

Staff had received training in equality and diversity, were given a summary of the course content on a laminated sheet and discussions took place in staff meetings. Staff gave examples of people they had supported in relation to their culture or beliefs. The chef asked people when they moved to the service about any specialist diets and had catered for people who did not eat certain types of meat or any fish. Another staff member told us that when one person had died their family members had washed and dressed their body according to their beliefs. This staff member told us that all staff knew not to attend to the person's body on their death as it had been recorded at the front of their care notes.

Staff felt well supported by their colleagues, senior staff and the management team. They said there was good communication in the unit in which they worked and that they received supervision attended unit staff meetings and had a yearly appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

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 attended training in on the MCA and understood its main principles and how to put them into

practice. They understood that people had the capacity to make daily choices and decisions in relation to their personal care and independence, but sometimes they were not able to do so and so made these in their best interests. Care plans contained assessments with regards to people's capacity to make choices and decisions and indicated when staff may need to act in people's best interests. A record had been made of best interest meetings and decisions. Staff gained people's consent and explained how they were going to support people before giving them their medicines and assisting them to move around the service.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes ard hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made for people who may be restricted in their freedom and these were incorporated into people's plans of care.

Requires Improvement

Is the service caring?

Our findings

People and their relatives said that staff were kind and caring. When asked if staff treated them with kindness one person told us, "Staff are very patient with me" and another person said, "I like living here. It is a good place to live". Comments from relatives included, "Staff are always on the watch to make my relative's life comfortable"; "Staff are dedicated and go the extra mile. When I've not had a good day with my mum, I can go out of here knowing she's well cared for"; and "Staff are very caring and it is the little things they do that makes a difference". Relatives said that staff gave people emotional support when it was needed. One relative told us, "The staff are definitely kind and caring and give people cuddles when they are upset". Another relative said, "My mum doesn't like going in the hoist which can be quite distressing for her. Staff sing to her which helps to calm her".

Feedback was that people were always treated with dignity and respect and that their independence was respected. Examples of how this was achieved were that staff always knocked on people's doors before entering; and that when providing people with personal care, staff did so in a way that respected their privacy and chatted to them to put them at ease. A relative told us, "When doing personal care staff will offer my mum a flannel so she can do it herself. But if she doesn't want to staff will carry on supporting her". However, we found there was inconsistency in staff understanding and practice in providing compassionate, respectful and empathetic care.

Most people benefitted from staff that showed concern for their well-being and responded in a caring and meaningful way. Staff greeted people by name when they saw them, asked them how they were and took time to listen to their responses. Staff used appropriate physical touch. They touched a person to reassure them, offering a helping hand to guide a person and joined in hugs if they were offered or initiated them when people were upset which had a calming effect. Staff listened to people and talked to them in an appropriate way so they could understand. When speaking to people staff adjusted themselves so they were at the same level as the person and maintained eye contact so it was easier for the person to hear and join in the conversation. Staff also made people feel valued and praised them for their achievements. They commented to some people on their smart appearance and how good people looked after having their hair cut at the hairdressing salon. When taking part in activities people's participation and contribution was acknowledged.

Some people were not treated in a way which respected their dignity. One person who presented behaviours that could challenge was aided to sit by a staff member but the staff member stood in a way which made it difficult for the person to stand. After we brought this to the attention of a senior staff member a new member of staff then supported the person according to their behavioural plan. They engaged them in throwing and catching a ball and taking them for a walk. They knew the person well so anticipated their needs to avoid harm. When the person moved their body to make physical contact with the staff member, the staff member reacted quickly and stepped back to avoid any contact.

Another person asked to go to the toilet, but instead of responding, staff suggested they first drink their drink and eat their cake. When the person repeated that they needed the toilet, staff responded that there

was no one available to take them. It was only after this a senior member of staff intervened and assisted the person as they requested. At lunchtime in one unit some staff stood over people who were seated, in order to assist them to eat. Staff focused on the task of feeding the person rather than involving them and promoting the meal as a positive experience. Staff did not explain to the person what they were going to eat and engaged them in limited conversation.

The provider had failed to make sure that people's privacy and dignity was respected at all times. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives said they were involved in decisions about their care and treatment. One person told us, "I choose what time I go to bed. Staff come to see me in the morning and I can tell them to come back later if I don't want to get up yet". A relative said, "My mum chooses to spend time in her room. If she doesn't make an appearance at lunch, someone will check to see if she wants to come". Relatives said that as most staff had worked at the service for a long time, that they knew people well and how to care for them in an individual manner and in relation to their gender and culture. People said that male and female staff were available to support them and they had been asked for their choices and preferences and these were respected. One relative told us, "Staff call my mum by her preferred name. They understand what makes her laugh and share jokes with her. Staff also get to know us as a family". Care plans included information about people's individual methods of communication such as if they could understand a conversation, required simple instructions, or if staff needed to be mindful of a hearing or sight impairment.

The service gave people and their family member's information about advocacy services available which provided independent support and advice. Leaflets about the local services and their contact details were also kept in people's care files so staff that cared for the person were aware of them and could access them when needed.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives said staff were responsive to people's needs. One person told us, "I can't walk so I get someone to take me to the toilet. Staff come as quickly as they can". One relative was highly complementary about how the service had adapted and responded to meet the needs of their loved one. "He has been to three day centres and they couldn't cope with him. He went to respite and they sent him home after one night. Here he has made it home from home. We have observed staff at different times and they are all incredibly hard working and couldn't be kinder". Other comments included, "My family member has on occasion taken exception to a particular member of staff and they have made adjustments"; and "If mum has a bad night they see if she wants a lie in or if she wants to go to bed early".

Feedback was that people were encouraged and supported to maintain relationships with people who were important to them. Family members said the service was good at communicating with them and keeping them informed of any changes in a person's care. One relative told us, "We are happy with mum here. It is not just the care she gets; it's the support we get too". People were able to follow their religion and beliefs. During the a priest visited and a member of staff read a bible to one person. Regular Christian services took place at the service, which reflected people's beliefs.

People and their relatives said there were a range of activities on offer, but in some units this variety and frequency had reduced due to activity staff vacancies. People told us they took part in bingo, had their nails painted, read newspapers and magazines, were taken out by staff for walks and that entertainers such as singers and animal handlers visited. "I like going across (to another unit) to listen to the sing song", one person told us. A relative said, "A couple of months ago they had zoo lab here and we saw snakes".

The activity manager was responsible for overseeing activities across the service. They organised an activity in one of the units each afternoon which people from the other units were able to attend. This included quizzes, bingo, music for health, arts and crafts, pamper sessions and activities centred on seasonal events. For example, a relative told us people had specially decorated mugs at Halloween and some units contained decorations for Remembrance Day. The afternoon group bingo session during our visit involved around 18 people and the activity manager confirmed this was the usual number of people who attended these sessions. This was a positive experience for people who were encouraged to fully engage in the activity. There was laughter during the tea break and people's achievements were valued as those who won a game were able to choose a prize. Morning activities were organised by each units' activity coordinator. However, there were two staff vacancies so in these units a member of the care staff team who was responsible for directing activities.

There was an inconsistency people's experiences of how they were supported to follow their interests. Where an activity coordinator was based in a unit they had checks in place to make sure everyone was involved and adapted activities to people's abilities and interests. For people who did not engage well in group activities they made sure they received one to one attention such as reading to them, engaging them in a particular object or listening with them to music. Units without an activity coordinator were reliant on a member of care staff taking the lead and this depended on how busy they were with care tasks. We observed

periods where people in some units spent long periods of time with little stimulation which resulted in them going to sleep.

The service provided care for a large number of people living with dementia. Sensory boxes were available and contained items such as balls and soft toys. These were inconsistently used across the service and with varying success. Some people were able to explore the boxes themselves and appeared to enjoy doing so, but other people needed staff guidance about what to do with the items which was not available. The boxes contained general items and therefore may not have any meaning to the person to whom they were given. Lounges contained activity areas which were activity used in units where an activity coordinator was in place. In other units these were not in use and items and objects were not easily accessible.

We recommend that the provider reviews the way it provides activities and stimulation so it meets the needs of all people at the service.

People knew how to raise a concern or complaint and felt comfortable doing so. People and their relatives said they would approach a member of the care staff, nurse or unit manager if they had a concern. They said that staff were approachable. Feedback was that no one had raised a concern recently, but that when they had done so in the past, their complaint had been resolved to their satisfaction. Information about how to make a complaint was displayed in the service. The compliant policy set out how to make a complaint and timescales for response. It included the right for people to direct their concerns to the Ombudsman if they were not satisfied with the way the service had handled their complaint. A record was kept of each complaint with the details, actions and progress of the complaint investigation.

Relatives told us that their family member had a care plan which set out their care needs and how they could be met. They said that they were consulted about the development of the plan and involved in any changes and reviews. There was a summary of people's physical, mental, emotional and social needs at the front of each person's care file which gave staff an overview. This included how to communicate with the person, what support they required with their personal care, if they needed support to move and any health issues that needed to be attended to. Where people were living with dementia guidance was in place for staff about how this impacted on their well-being. For example, for one person it had been recorded that their dementia affected their short term memory and resulted in them being disorientated and confused at times. People's changing needs were monitored and observed by staff on a daily basis and a record was made in their daily notes. Care plans were regularly reviewed and dated to indicate when people's needs had changed. Information about people's personal history, individual preferences, likes, dislikes and interests was sought. For example, one person had indicated that they liked to have their door open at night time or they became anxious. Another person's plan stated that they liked singing and colouring and had taken part in these activities.

Relatives said they were involved in discussions about how to support people at the end of their lives. One relative explained this difficult conversation as, "Very sensitively and carefully explained by staff". Another person described how the service worked in partnership with the local hospice to make sure their family member's changing needs were regularly reviewed. They said that anticipatory medicines were in place to manage their symptoms and pain at the time when it was needed.

People and their family members were asked about any future decisions and choices with regards to their care. This included if they had any religious or spiritual beliefs, choices about where they wanted to be cared for at the end of their life and there was a staff prompt to complete an advance care plan as appropriate. Advance care plans set out what is important to a person in the future, when they may be unable to make their views known.

Requires Improvement

Is the service well-led?

Our findings

The majority of people and their relatives were positive about people's experiences at the service. People told us that there were no formal meetings to discuss their views and feedback, but that a resident meeting had been arranged for the following week. One person told us, "I'm supposed to be the resident representative, but I have not been to a meeting yet, so I am not sure what it entails". Relatives said they had completed an annual survey to ask for their feedback. One relative said they had asked for improvements in the environment and that this had been addressed. Another relative said they had been asked for ideas about activities and suggested a knitting circle, which had taken place.

There was a lack of strategic oversight and management of the service which had a direct impact on the quality of the care and support people received. The quality monitoring systems for the service had failed to identify shortfalls and inconsistency in practice across the service in relation to medicines management, assessment of risk support for people at mealtimes and respecting people. Therefore, the service could not demonstrate it was continuously evaluating and learning from events to drive forward improvements in service delivery.

A representative from the service carried out quarterly audits which were looked at if the service was safe, effective, caring, responsive and well-led. The last audit found that people received positive experiences in all these areas and across all units. There were few comments about how this was being achieved for such a large and complex service. However, a visit by the local authority in September 2017 highlighted a number of shortfalls in clinical governance which had not been identified through the service's quality monitoring systems. Staff told us the service's clinical governance lead had been absent from the service for several months and we received mixed responses about how the role was being fulfilled in their absence. A home improvement plan was in place to address these shortfalls. Each unit was responsible for undertaking audits in key areas such as falls, hospital discharges, safeguarding, wound care, specialist diets and at end of life care. It was the responsibility of the unit manager to escalate significant issues to the management team, but this had not always occurred. One person had a pressure area which national guidelines recommend is reported as a potential safeguarding so checks can be made to ensure the service is providing appropriate treatment. The provider only notified the safeguarding team and The Commission once this had been brought to their attention.

Records in respect of people's care and treatment were not always accurate or easily accessible which meant that people may not receive the support and treatment they required to meet their needs. Some records held on the computer could not be assessed during the inspection as there were technical difficulties. These technical difficulties continued after the inspection which resulted in a delay in them being sent. The paper record for the September medicines audit for one unit could not be found during the inspection visit and was sent after the inspection. Handover records were inconsistent between units. On some units staff wrote their own notes after a verbal handover and on one unit staff were provided with a summary of people's needs which was inaccurate as it included people who no longer used the service. For one person who required hourly observations, the records had not been completed after entries that the person was asleep. On 3 November 2017 this included the time period from 3pm to 10pm. One person's

diabetes care plan contained clear guidance to staff about when to check their blood sugar levels and what to do if they were higher or lower than expected. However, another person's care plan stated their blood sugar levels should be checked weekly, but staff informed us that this was not necessary.

The provider had not ensured people's records in respect of their care and treatment were accurate or accessible. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said that management team had an open door policy that they felt well supported and their views were listened to. The service had recognised the outstanding contributions of two staff members and had nominated them for The Great British Care Awards. These awards are a series of regional events across England to celebrate excellence in the care sector. The aims of the service were to provide care in a personalised way and to be passionate about doing so. Staff said they were proud to work for the service and the most staff demonstrated they put these aims into practice, knew people well and showed compassion and genuine interest in people's welfare. However, not all staff understood how to put these aims in to practice which was demonstrated by staff standing over people when supporting them and being unresponsive to their needs with regards to eating and personal care.

People and their relatives were asked for their views using an annual satisfaction survey questionnaire. They were asked for their views on their involvement, the environment and activities. The last time this took place was in 2016 and the results had been analysed and showed that the majority of people were highly satisfied with the service they or their relative received. 92% responded that they were treated with dignity and respect; 88% that the service was safe and secure and 80% that they were listened to by staff. Comments included, ""I like the staff, and they are so patient. They really helped me when I was sick"; "Nice friendly staff caring for mum's needs. Clean happy environment. Always staff about to help in any way possible"; and "Communication is excellent". The providers responses to people's views were displayed in each unit in a 'You said, We did' format. For example, in one unit people had asked to try a variety of different cheeses at a taster day and this had occurred. Resident meetings had taken place shortly after our inspection visit and included discussions around any news, customer feedback, housekeeping, catering and staff training.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception area and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported appropriately at mealtimes. Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated in a dignified or respectful manner. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The administration and recording of medicines did not always ensure people were given their medicines as directed by their doctor. People could not be assured they would receive care in a safe way as the service was not doing all that was practicable to respond to significant events and mitigate assessed risks. Regulation 12 (1) (a) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

Treatment of disease, disorder or injury

governance

Systems in place for assessing, monitoring and improving the service were not robust.

People's care and treatment records were not all accurate, or accessible to ensure people received the care they required.

Regulation 17 (2) ((a) (b) (c)