

Abraham Health Care Limited

Glenkindie Lodge

Residential Care Home

Inspection report

27 Harborough Road
Desborough
Kettering
Northamptonshire
NN14 2QX

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09 October 2018
16 October 2018

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18 December 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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This unannounced inspection took place on 9 and 16 October 2018.

Glenkindie Lodge Residential Home was registered by the Care Quality Commission (CQC) on the 2 November 2017 and this was the first time we had inspected this service.

Glenkindie Lodge Residential Home 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.

Glenkindie Lodge Residential Home provides care and support for up to 33 older people, some of who may be living with dementia. The premises had been adapted and consisted of two floors which included bedrooms, a main lounge, garden room, dining room and an activities room. At the time of our visit there were 26 people using the service.

There was a registered manager in post. 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.

During this inspection we found that risks to people had not always been identified and managed safely. For example, where people were using thickener in their drinks because of a risk of choking, there were no risk management plans in place to cover the risk of choking or dehydration. One person had numerous falls from their bed, but there was no risk management in place to help reduce that risk.

Mobility assessments did not always demonstrate how moving and handling slings had been safely assessed for people. People shared slings but we found they were not always used correctly, for example, toileting slings were used for general moving and handling procedures, not toileting. Slings were not checked to make sure they were safe to be used. Some people using wheelchairs were at risk of sliding out and there were no management plans in place to reduce this risk.

Some bedrooms doors had been wedged open with different pieces of furniture which meant that people may be put at risk if there was a fire at the service. Not everyone living at the service had in place a personal emergency evacuation plans (PEEPS) to make sure they would get the help they needed in an emergency to keep them safe.

Quality assurance checks were not used effectively to bring about improvements to people's care and support. Records management was confusing and disorganised and records could not always be accessed at the time of our inspection.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Improvements were required to ensure people were protected from the spread of infection and that the service followed best practice guidance. We found that people were sharing slings used for moving and handling.

Senior staff required further training in relation to the Mental Capacity Act 2005 (MCA) and the process for making best interest decisions for people. Staff understood about safeguarding and the many different types of abuse. They knew how to report any concerns they may have. There had been ongoing recruitment by the provider to improve staffing numbers and the provider followed thorough recruitment procedures to ensure staff employed were suitable for their role.

People's medicines were managed safely and in line with best practice guidelines. There were arrangements in place for the service to make sure that action was taken and lessons learned when things went wrong, to improve safety across the service. These needed to be strengthened to make sure that the outcomes of accidents, incidents and complaints were shared with all staff to ensure lessons were learnt to reduce the possibility of a recurrence.

People received a needs assessment before they went to live at the service. The induction process had improved to make sure all new staff completed the Care Certificate. The registered manager provided all staff with on-site training that covered core subjects such as moving and handling, fire safety and food hygiene. However senior staff needed further training in Mental Capacity and Deprivation of Liberties. People received enough to eat and drink and staff gave support when they needed help to eat their meals. People were supported to have health appointments when required, including opticians and doctors, to make sure they received healthcare to meet their needs.

The staff were caring and kind and had developed good relationships with people using the service. They engaged with people and welcomed their relatives and friends when they visited. Staff respected people and supported them to make choices about their care and support. People told us staff treated them with dignity.

People were happy with the care they received from the staff team. Staff found the care plans were not easy to use and they found it difficult to find the information they needed. Although some improvements were already taking place in relation to the activities people took part in this needed to be strengthened to make sure people were able to take part in activities that were meaningful to them. The service had a complaints procedure and if a person made a complaint they were listened to and their concerns taken seriously. People could be supported to plan and make choices about their care at their end of life.

The service had a new provider and was registered with CQC on 02 November 2017. This was the first time we had inspected the service under the new provider. We found that the provider had already identified many areas of the service that required improvement. They had drawn up a development plan and were working through this. Improvements that already taken place included upgrading the environment, purchasing new equipment, changes to staffing. After our inspection the provider wanted to confirm with us further improvements they had introduced. These were the introduction of a new electronic records system to improve record keeping and training for the registered manager and the deputy manager in relation to Deprivation of Liberties (DoLS) training.

The provider told us he was committed to improving the service and showed us their plans for the future. These included more specialist training for staff and the registered manager, for example, end of life care and managing behaviours that can challenge. There were plans to continue to improve the provision of activities for people and to introduce new quality assurance systems to monitor the standard of care to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Risks to people had not always been identified and managed safely and people were not always protected against the risk of infection.

The provider had systems in place to safeguard people from abuse. New staff been recruited safely to ensure there were sufficient numbers to meet people's needs. People received their medicines as prescribed.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff needed further training in relation to the Mental Capacity Act and Best Interest Meetings. The provider had made Improvements to the systems in place for supervising staff and there were on-going improvements to the environment.

People's care needs were assessed and met by staff who were skilled and had completed the training they needed to provide peoples care. People were supported to maintain their health and well-being and staff helped to ensure people's nutritional needs were met.

Is the service caring?

Good ●

The service was caring.

People were supported by staff who were kind and caring. They took time to ensure that people understood what was happening and supported people in a patient and encouraging way when they were moving around the service.

Staff respected people's privacy, dignity and independence ensuring people were involved in decisions about their care.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care plans were confusing and were not user friendly. They had not always been updated to reflect changes in people's care. The provision of activities for people needed to be strengthened to ensure they met people needs.

People were positive about the care they received and felt able to complain if they had any concerns. People were supported to plan and make choices about their care at their end of life.

Is the service well-led?

The service was not always well led.

Systems in place to assess, monitor and improve the quality and safety of the service needed to be strengthened and improved.

The registered manager had not always encouraged an open line of communication with their team and staff did not always feel well supported by the management.

People told us they were happy with the service they received and were asked for feedback about their experiences.

Requires Improvement 

Glenkindie Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 09 and the 16 October 2018 and unannounced. The inspection was carried out by three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service. This included concerns received about the service and notifications we had received from the provider. A notification is information about important events and the provider is required to send us this by law. We reviewed the provider's statement of purpose. A statement of purpose is a document that describes the facilities and services, what people can expect to receive and the provider's philosophy of care; visions and values. We asked commissioners from the local authority for their feedback about the service. We used this information to plan the inspection.

We 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 spent time observing care and support in the communal areas and we observed how staff interacted with people who used the service. We spoke with ten people using the service and four relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with eleven staff that included the provider, the registered manager and seven care and support staff. In addition, we also spoke with a member of the housekeeping staff and the chef. During our inspection we were also able to have discussions with three visiting health professionals.

Over the course of the two days we reviewed records which included nine people's care records and twelve people's medication records to see how their care and treatment was planned and delivered. We reviewed five staff employment records and other records which related to the management of the service such as policies and procedures, staff training records, the staff rota and quality assurance audits.

Is the service safe?

Our findings

Risks to people had not always been identified and managed safely. People had individual risk assessments to enable them to be as independent as possible whilst keeping them safe. They covered a variety of subjects including, moving and handling, falls, nutrition and tissue viability. However, we found that some areas of risk to people had not been identified and management plans were not in place to reduce the risk to people. For example, where people were using thickener in their drinks because of a risk of choking, there were no risk management plans in place to cover the risk of choking or dehydration. A further example included one person who had had a number of falls from their bed, and had sustained an injury because of this. There were no risk management plans in place to reduce the risk of the person falling. We spoke with the registered manager who told us they take action to address this.

One the first day of our visit we found a spray bottle in one person's bedroom that had the original label removed and 'urine neutraliser' hand written on it. The registered manager stated that this had probably been left by the house keeping staff during their morning cleaning routine. The room was not locked making it accessible to people using the service, placing them at risk of harm.

During our visit two staff raised concerns about people's moving and handling slings. One told us, "The slings don't always fit people properly." We found that mobility assessments did not always demonstrate how moving and handling slings had been safely assessed for people. For example, we saw there was one small sling that should be used to support people to use the toilet and was used jointly for at least three people. However, we found that this sling was used for general moving and handling manoeuvres and not for toileting purposes. We were unable to find a rationale for this. We asked the registered manager why this was the case and they told us it was because this was how it had always been done. In addition, there was no system in place for checking the condition of individual slings to ensure they were safe to use and fit for purpose. We found one sling that was very worn and frayed around the seams that was being used for at least three people. This did not ensure that slings were suitable and safe for people to use. The provider told us they were immediately going to assess everyone that needed a sling for moving and handling to ensure everyone had their own slings. Since our inspection the provider has told us that they have ordered new slings.

We also saw two people sitting in wheelchairs. They had no footplates and no seat cushions in place. This had the potential to put people at risk of injury or pressure damage Both people were sliding down the wheelchairs and were at risk of sliding out their chairs. There were no safety belts or risk assessments in place to reduce the risk of falling.

During our visit we saw that two bedrooms doors had been wedged open with different pieces of furniture. Wedging fire doors open meant that people may be put at risk if there was a fire at the service.

We saw that plans were in place to respond to emergencies, such as personal emergency evacuation plans (PEEPS). However, not everyone had a PEEP in place and we saw that one person had a PEEP but it stated the person was in a different room to where they were. This did not provide assurance that people would

receive the appropriate level of support in an emergency to keep them safe.

Risks to people had not always been assessed and their safety monitored to ensure they were supported to stay safe while living at the service. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

Since our inspection the provider has informed us that they have strengthened the risk management strategies for people who were assessed as at risk of choking. We have not been able to assess that these strategies have been embedded into practice and will assess the action that the provider has taken in our next comprehensive inspection." There was more than one person at risk of choking and therefore the additional evidence does not fully address the concerns raised.

People and their relatives told us they thought the service was clean and hygienic. One person told us, "They keep my room lovely and clean." A relative said, "There are always staff cleaning." Staff we spoke with could describe infection control procedures and told us they had plenty of personal protective equipment (PPE). The registered manager told us they were the lead for infection, however none of the staff we spoke with were aware of this.

We found there were some areas that required improvement, for example, people did not have their own slings. One member of staff commented, "The residents don't all have their own slings and some of them are incontinent." The registered manager confirmed this was the case. The new provider told us that plans were in place to provide people with their own slings for those who required it. We saw this was included in the provider's improvement plan. We also found that one person's mattress was badly stained. We brought this to the registered manager's attention who said they would ensure the mattress was replaced. Relevant staff training in infection control and food hygiene had taken place. Since our inspection the provider has told us that they have ordered new slings.

The provider had systems in place to safeguard people from abuse. People told us they felt safe living within the service, and with the support that staff gave them. One person told us, "Oh, I feel perfectly safe here. There is always someone to look after me." A relative commented, "[Name of relative] is safe here. I have no worries about their safety."

We talked with staff about safeguarding people from abuse, and they were all clear on the correct procedures to follow. One staff member said, "I would talk with the manager. If I didn't think it was being dealt with I would go to CQC." Staff told us that they had been trained in relation to safeguarding people from abuse and records we examined confirmed this. The new provider had ensured that information about how to report safeguarding alerts and whistleblowing concerns were displayed and accessible to all staff. One staff member told us, "The owner has met with staff and we have their phone numbers if we need to speak with someone." We saw evidence that the provider had submitted safeguarding alerts to the local safeguarding team as required.

Most people said there were enough staff available to meet their needs. One person told us, "I can get help 24/7 if I wanted it and I couldn't get that at home, even though I miss home sometimes." A relative said, "I think there is enough staff. The new owners have made lots of changes and they have improved the staffing. They are always around as well. It's a good change." However, one person commented, "Sometimes when I press my call bell I have to wait for a long time." Over the two days of our inspection we saw that call bells were responded to promptly. A visiting professional told us, "There has been quite a turnover of staff in the past, but this has settled down now and since the new owner, there have been less recurring problems. Whenever I visit, it seems that there are enough staff to cater for the resident's needs."

We had mixed views from staff about staffing numbers. Most staff said they were satisfied with the number of staff on each shift. However, two staff members said they would benefit from an extra staff member in the morning. One commented, "There are not enough staff especially at times when we need to support people with toileting and breakfast, mealtimes, bedtime and responding to call bells. It's really busy." We discussed this with the registered manager who said there were plans to introduce an extra staff member per shift and another staff member between 16:00pm and 20:00pm as these were peak times when extra staff were required.

The registered manager told us that a dependency tool was completed and staffing hours were based on this information. She said she would continue to monitor staff numbers on all shifts to ensure there was always enough staff on duty to meet people's needs. On the first day of our visit we observed sufficient numbers of staff to support people, however on the second day a staff member had gone off sick and staff were rushed. The provider told us they had recently recruited more staff and some were on their induction at the time of our visit. We saw a senior staff member who was on their first day working at the service and they were shadowing a more senior staff member.

People were safeguarded against the risk of being cared for by unsuitable staff because the provider followed thorough recruitment practices. We saw that the provider had recently recruited numerous care and ancillary staff and that recruitment was on-going. Checks on the recruitment files for five members of staff evidenced they had completed an application form, provided proof of identity and had undertaken a Disclosure and Barring Service (DBS) check before starting work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Four of the five files contained only one reference. Following the inspection, the registered manager sent us confirmation that two references had been obtained for all staff. The records we looked at confirmed all staff were subject to a formal interview, which was in line with the registered provider's recruitment policy.

Prior to the second day of the inspection we received some concerns in relation to the safe administration of medicines. These included concerns that medicines were just placed in front of people and staff did not observe people to make sure they took their medicines. This meant that tablets were often found on the floor around the home.

People told us that they received their medicines when they expected them. One person told us, "I get my pills three times a day and mostly I remember what they are for but the staff will always remind me if I forget." A relative commented, "They [meaning staff] do tell me if there are any changes to [name of relative] medicines. I don't have any worries about [relatives] medication." A staff member commented, "I have had medication training. I feel confident."

We observed a staff member giving people their medicines. This was undertaken in a person-centred way, with each person being asked if they were ready for their medicines and how they wished to take it. We observed that staff stayed with people until they took their medicines. One person refused their medicines and we saw that the staff member respected their wishes and followed the correct protocol. There were some gaps in the Medication Administration Records (MAR) where staff had failed to sign for medicines given to people. We saw the registered manager had completed medication audits and had identified areas for improvement. However, these had not been actioned. Medicines were stored safely, there was a system for recording the receipt, and disposal of medicines to ensure staff knew what medicine was in the service at any one time. This helped to ensure that any discrepancies were identified and rectified quickly.

Staff understood their responsibilities to raise concerns in relation to health and safety and near misses. The

new provider was making improvements to the service by using lessons learnt from reported events and complaints. For example, we saw that a recent complaint from a relative had been thoroughly investigated by the new provider. A comprehensive action plan had been drawn up as a result of the concerns raised. This had been shared with senior staff. However, systems needed to be strengthened to ensure that the outcomes of accidents, incidents and complaints were shared with all staff to ensure lessons were learnt to reduce the possibility of a recurrence.

Is the service effective?

Our findings

There was an assessment process in place to identify people's needs before they were admitted to the service. We saw that the service worked with local authorities in taking referrals and assessing people's needs. They would also involve any healthcare professionals if it was felt necessary. We saw that each person had received a pre-assessment of their needs before moving in to the service. However not all assessments had been fully completed. For example, we saw that in people's files there was an 'about me plan'. This gave staff personal information about people's likes and dislikes. This had not been completed for everyone. In addition, not all assessment documentation demonstrated who had been involved in the initial assessment, for example family members or friends.

People told us they thought staff had the right skills and knowledge to care for them. One person told us, "I can't do things for myself, but the staff help me in just the right way." A relative commented, "I see the staff cope with people who are very confused and upset. They manage situations confidently. It's because they know the residents well."

The registered manager told us that staff completed an induction programme when they first commenced working at the service. However, the training matrix provided on the day of our visit showed that only one person had completed the Care Certificate in 2016, which was available to staff. The certificate is based on 15 standards and aims to give employers and people who receive care the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. The registered manager informed us that the training matrix needed to be updated and since the new provider had taken over all new starters were expected to complete the Care Certificate. Following the inspection, the registered manager provided us with an updated copy of the staff training matrix. This showed that 15 new staff were currently undertaking the Care Certificate.

The registered manager told us they delivered all the staff training on site. We asked them about their qualifications to do this. For example, moving and handling training. Following the inspection, they provided us with up to date certificates to demonstrate they were qualified to provide this training to staff.

Staff told us they completed training in core subjects such as moving and handling, food hygiene, safeguarding and fire safety and the staff training matrix confirmed this. All staff had also recently completed dementia training. Staff told us they felt they would benefit from further training such as end of life care and managing behaviours that could challenge. Following the inspection, the provider had included this training into their improvement plan.

Records demonstrated that staff had not previously received regular supervision with a line manager and there were no records to confirm that regular supervision had taken place. However, the provider told us they had commenced supervisions with staff and at the time of our visit 16 supervisions had been completed and we saw records to confirm this. One staff member told us, "We don't usually have any supervision, but the new owner has started doing this with the staff. I had my supervision and it was really positive. I felt like I was being listened to and my ideas were taken seriously. I feel the new owner really

wants to make changes for the better. They gave me their number if I felt that I wanted to discuss anything. I believe they care about us." A second member of staff commented, "It was good to have the chance to speak up. I was honest and spoke about things I didn't think were good and the new owner listened and encouraged me to talk." We saw that as a result of staff supervisions, changes had been made for improvement. For example, staffing structures had been implemented in each department, such as catering and housekeeping, with a head of department taking the lead for each area.

People had enough to eat and drink. One person told us, "The food here is nice. There is plenty of it, although I sometimes forget what I have asked for (food was chosen the afternoon before), but they [meaning staff] will always change it if I don't like it." Another person commented, "The food is good; it's hot and well presented, although we have waited up to an hour to be served before now. It was much better today." (This was the first day of our visit.)

On the first day of our inspection we saw that the lunch time meal was an enjoyable and positive experience for people. People were provided with a choice of meals and had the freedom to eat in the dining room or their own rooms. Staff were attentive and all interactions we observed were respectful of people's needs. However, on the second day we found that staff were rushed and people were sat waiting for a long time between courses. One staff member who was supporting a person with their meal needed to call for assistance on two occasions as they could not leave the person they were supporting. We were informed that this was because a staff member had gone off on sick leave which meant there was a deficit in staffing numbers that day.

Records of people's dietary and hydration needs had not always been fully completed. For example, the fluids recorded on handover documents did not always match charts kept in the kitchen and we found that weights had not always been recorded monthly. The provider told us they were going to implement a new electronic records system that would make monitoring and recording easier.

People had access to healthcare facilities and were supported to attend health appointments. A relative told us, "[Relative] is very well looked and the staff will get professional help if it is needed. I know [relative] sees the doctor and the chiropodist regularly." A member of staff said, "We have a good relationship with the district nurses and the doctors. We would have no hesitation about making sure people see the correct health professional if they needed to."

A visiting health professional who visited the service regularly told us, "There have been improvements in the home in the last few months since the new owners had taken over. Previous to this we had concerns. Staff are making early contact regarding concerns with pressure areas (to prevent pressure sores developing) now. The new owners are keen to push forward with training for staff and getting suitable staff on board. They have requested that going forward we have a monthly meeting to discuss any concerns and look at how they are going to manage care. The new owner has been a regular presence in the home."

People were supported by staff to use and access a wide variety of other services and social care professionals. The staff had a good knowledge of other services available to people, and had good communication with professionals including social workers, reviewing officers and other healthcare professionals. We saw that input from other services and professionals was documented in people's files.

There were on-going improvements to the environment and many improvements had already been made. We completed a tour of the premises with the provider. As part of the environmental improvements we saw that all the communal areas, including the lounges, activity and dining room, hallways and the corridors had been refurbished. Additionally, improvements had been made to other areas of the service such as care and

support equipment that included new hoists, new bedding and entertainment units. Office and IT equipment, boiler and heating systems and laundry and kitchen equipment had also been repaired or replaced.

Where we found any areas of concern in relation to the premises the provider was quick to act and ensure it had been rectified in a timely manner. The provider had an on-going refurbishment and improvement plan that they sent to us following the inspection. This showed plans to make the service more compatible to the needs of people living with dementia.

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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

We found there was a blanket approach to completing MCA assessments and staff knowledge and understanding about the process to be taken for completing best interest decisions needed to be strengthened. For example, when questioned, the registered manager thought that best interest decisions were decided by the Deprivation of Liberty's (DoLS) team. We asked about the process they would complete while waiting for a DoLS decision, to assure herself that she was acting in the best interests of a person. They were unable to give a suitable answer around best interest meetings and demonstrated a lack of knowledge about the whole MCA process. There were no records of any best interest meetings available for us to examine.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). A DoLS provides a process by which a provider must seek authorisation to restrict a person's freedoms for the purposes of their care and treatment. At the time of our inspection there was one person with a DoLS authorisation in place. The registered manager told us they had applied for several others and was awaiting an outcome. They did not have a list of who they had applied for at the time of our visit and we asked for this to be provided following the inspection, which they did promptly. They also provided us with confirmation that they and the deputy manager were to attend DoLS training in November 2018.

Is the service caring?

Our findings

People we spoke with were positive about the care they received and told us they were happy living at the service. One person said, "I can honestly say that all the staff are lovely to me. I'm happy here." Another told us, "The staff are very good here and we often have a bit of banter." Relatives also echoed these sentiments. One commented, "They are a good team of staff here now, although they have had a lot of changes. Its settled down and the repairs to the home are making it a nicer place to live and work I think."

We observed that staff spent time interacting with people and addressed them by their preferred name. Staff supported people with care and compassion. For example, we observed one person who became anxious about the lunch time meal. The staff immediately responded to the person in a calming and soothing manner which the person responded positively to. Staff managed the situation well and with the person's permission, agreed that they might be happier in an adjoining quiet room, where their meal was subsequently served.

Compliments received from people and relatives included, 'I know [relative] found all the staff kind, courteous and most of all supportive and friendly when they were not feeling so great.' Another read, 'Although we know [relative] could be challenging it has been of great comfort to us to hear of the fun and laughter you shared with them.'

Staff took time to ensure that people understood what was happening and supported people in a patient and encouraging way when they were moving around the service. For example, one person said they wanted to go back to their room. This involved staff using the hoist to move them. Then the person changed their mind and then changed it back again. The staff member was very patient, knelt down so the person could see them and the staff member did not take any action until they were positive about the person's decision. We saw that staff provided people with reassurance by touching and giving eye contact when talking to people.

Staff interacted with people positively, they supported them with their diverse needs and had a good understanding of their social and cultural diversity. For example, we saw one person liked to dress a particular way and also liked to wear make-up and staff supported them with this.

People confirmed that they were able to make day to day decisions about their care and support. "One person told us, "I am involved in my care and I tell the carers how and when I like my shower." A relative commented, "My family are always made welcome, they keep us informed of anything that happens to [relative] We are able to give our ideas for [relative]."

We saw that people and their relatives were given the opportunity to express their views about their care through regular reviews and records we saw confirmed this. The registered manager told us they would provide people with information about how to access advocacy services if required. An advocate is an independent service which is about enabling people to speak up and make their own, informed, independent choices about decisions that affect their lives. However, information was not displayed for people to see. We discussed this with the provider who actioned this during our inspection.

The staff promoted the privacy and dignity of people and their families. One person told us, "The carers are very careful about their manners and how they treat me. They are very respectful." Another person commented, "Staff knew I wanted a shower and my hair washed this morning ready for the hairdresser. Staff are respectful when they are doing personal care."

We observed staff treating people and all visitors to the home with dignity and respect. Staff referred to people by their preferred name and spoke respectfully to people. They explained to people how they were supporting them, for example when a person was transferred by hoist, to reassure people and help them feel comfortable. We also observed that staff knocked on bedroom doors before entering and ensured doors were shut when they assisted people with personal care. They promoted people's choices and offered assistance if the person needed it, to help promote their independence.

Staff described the importance of confidentiality and not discussing people's needs unless it was absolutely necessary. Overall any private and confidential information relating to the care and treatment of people was stored securely. However, we found a staff handover book and a diary that contained personal information about people, on display in a corridor where the medication was stored. We discussed this with the provider who addressed this before the second day of our visit, ensuring all confidential information was stored securely.

Is the service responsive?

Our findings

People received an assessment of their needs before they were admitted to the service. Staff told us that before people used the service, people were asked for information about their needs. This information was then used to develop a care plan that reflected how each person wanted to receive their care and support. One staff member said, "People usually have an assessment when they are in hospital but sometimes they are still at home. We try to get as much information as we can, but the assessment is still happening when they arrive here and we get to know them better."

One person told us, "There is no pressure here. I do what I want when I want and the staff make sure I am ok and have everything I need. I'm happy with that." A relative commented, "We were involved when [relative] was first admitted to the home. If we have any suggestions they are usually taken on board."

We reviewed care records and found that people had been asked for information prior to moving into the service. Care plans we looked at had been reviewed regularly to ensure the care and support being provided to people was still appropriate for them. However, we found care plans were not user friendly and discovered different information was held in different places. For example, some information was kept in a staff handover book such as fluid intake for people while other information was recorded on daily charts. Some of these were in care plans and some were in people's rooms. A staff member told us, "All the information is kept in different files, in different places, it's very confusing."

As a result of this some records had not been maintained as regularly as they should be. For example, there were gaps in turning charts and food and fluid records. Daily notes recorded by staff were not very descriptive and some we looked at described people as "okay" "having funny turns" "not feeling themselves". We were unable to find if these concerns had been effectively followed up.

Some care plans had not been updated to reflect changes in people's needs. For example, we saw that one person who had been discharged from hospital was assessed as needing a pureed diet and needed thickener added to their drinks to reduce the risk of choking. However, staff told us the person refused thickener and that they were now back to a normal diet. There was no record of this in the person's care plan or any indication as to who made this recommendation. We discussed the care planning documentation with the provider. They told us that they were planning to introduce a new electronic records management system that would ensure records were completed in a timely manner and would make accessing information easier. Following the inspection, the provider sent us confirmation that they had acquired a digital care home management system which they would be introducing with immediate effect to improve records management.

We received mixed views from people and relatives about the activities provided. One person told us, "They [staff] know I like to go down to the religious service, so they always make sure they remind me. I enjoy that very much." Another said, "Some of the activities are good and some are boring. Nobody asks me what I would like to do." A relative commented, "[Relative] has been here for two and a half years. There are not enough activities for them. [Relative] doesn't have dementia so needs a different sort of stimulation but they

don't get that."

Staff expressed a desire to see more activities taking place for people. One told us, "We could do with more activities, [Name of activities coordinator] works from 9.30am until 2.30pm. Some of our residents are better in the evenings but we don't have time to do activities then, although I would like to." Another member of staff said, "There could be a better variety of activities. Sometimes they do the same things every week. I would like to take people out shopping or just for a coffee."

We observed activities taking place over the two days of our inspection. We saw people doing jigsaws and playing cards and colouring. Some of the activities were the same on both days. There were support plans in place for people's social care needs. However, these were very generic and were not personal to each individual. Support plans in place for spiritual care had not always been completed. People told us there was a monthly church service that they enjoyed. However, some people expressed concern that the person who took the church service was leaving and they would not be continued. We discussed this with the registered manager who was not able to say if this would be continued by another person.

We saw photographs of themed events that people had taken part in, such as making Easter bonnets. The provider also told us that one area of the garden had been improved to make access easier for people to use. As part of this improvement people were being encouraged to do some gardening such as flower pots and baskets.

The provider informed us that they had plans to improve the provision of activities for people and this was included in their development plan. These involved extending the number of activity hours to 10am to 4pm Monday to Saturday with Sunday being a day of rest. The provider informed us that they had already recruited a new activities coordinator and were just waiting for their recruitment checks to be finalised. They were also in the process of introducing and trialling new technology such as an electrical talking speaker which people could use to play music or other activities. There were also plans to create a sensory/reminiscent room.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider told us they could provide people with information in different formats if it was needed. The welcome pack that people received when they first went to live at the service was being reviewed and updated. The registered provider said they would add a notice in the welcome pack to make it clear to people that they could ask for this information in a suitable format that met their needs. We saw that some notices had been produced in large print and displayed around the service.

If people had any concerns or complaints they could use the complaints procedure in the 'welcome pack' they received when they began living at the service. This advised them they could complain in person, by phone or by letter/email, or get a friend or relative to complain on their behalf. It also explained to people how they could escalate their complaint to external agencies such as the local authority or the ombudsman. One person told us, "I know that I can make a complaint if I need to." The provider had also introduced a comments box where people and visitors to the home could raise any concerns, compliments and ideas at any time.

We saw a complaint from a relative that the provider had dealt with. The complaint covered numerous areas of concern about their family members experience. The provider had completed a very thorough investigation and had produced a detailed action plan with areas for improvement. The provider was still in

the process of implementing these changes as a result of the complaint. This meant that a person making a complaint could be confident that the provider would take action to resolve it and make improvements to the service where necessary.

Staff supported people who were at the end of their lives so they remained comfortable, dignified and pain-free. They worked closely with district nurses to ensure people's needs were met if they had reached the end of their lives. However, staff had not received any end of life training at the time of our inspection. We saw this had been included in the providers improvement plan. People's wishes for how they wanted to be cared for were in their care plans so staff were aware of these. Staff welcomed and supported the relatives and friends of people at the end of their lives.

Is the service well-led?

Our findings

There was a registered manager in post. The service had a new provider and was registered with CQC on 2 November 2017. This was the first time we had inspected the service under the new provider.

During this inspection we found that although there were quality assurance checks in place and completed by the registered manager, these were not used effectively to bring about improvements to people's care and support. For example, regular infection control audits were completed. However, they had failed to identify that the service was not following best practice guidelines to ensure all people had their own moving and handling slings to prevent cross infection.

Monthly medication audits had been undertaken and had identified omissions in the Medication Administration Records (MAR) where staff had failed to sign for medicines given to people. We saw an audit undertaken in May 2018 that had identified these issues. The action for improvement was for the relevant staff to complete external medication training. We asked the registered manager if staff had completed this yet and they informed us it had not been booked. During this inspection we found the same issues continued and we identified numerous gaps in people's MAR charts.

We found that monitoring systems in place had failed to identify risks to some people and they had not always been managed safely. For example, there were no risk management plans in place for people assessed as at risk of risk of choking or dehydration. Moving and handling slings had not been safely assessed to ensure people had the correct size and type of sling for moving and handling procedures. In addition, slings had not been regularly checked to ensure they were still safe to use and fit for purpose.

Care plan audits were completed on a monthly basis. These had failed to identify shortfalls in recording. For example, where people's needs had changed the care plans had not always been updated to reflect the changes. Checks of people's records had failed to identify gaps in their turning charts and food and fluid charts. This did not ensure there was a clear record of care to meet people's needs.

Records management was disorganised and we had to request numerous documents be sent to us after the inspection because they needed to be updated or could not be found at the time of our inspection.

Environmental checks had not identified the practice of wedging bedroom doors open and that PEEPS for the safe evacuation of people were not always in place.

Systems in place to assess, monitor and improve the quality and safety of the service needed to be strengthened and improved. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We spoke with the provider about our findings. Through discussion we found that the provider had already identified many of the same areas that required improvement as we had and they had drawn up a development plan to address the shortfalls. Many areas of the plan had already been completed, such as

upgrading the environment, purchasing new equipment, changes to the staff structure and recruiting more staff. Since our inspection the provider informed us that they had introduced a new electronic records management system to improve record keeping and had also

We saw that improvements were also planned with timescales set. These included more specialist training for staff and the registered manager. This included end of life care, managing behaviour that can challenge and Deprivation of Liberty's (DoLS) training. There were plans to continue to improve the provision of activities for people and to introduce new quality assurance systems to monitor the standard of care to improve the service.

People and relatives told us things had improved in the service since the new provider took over. Comments included, "There has been a lot of work done in the home, but it's made it much nicer." "I see the new owner around and he always chats to me." "There has been a lot of changes to the environment, making it a much nicer place to live and for us to visit." "I hope the new owners will carry on making improvements. They are always around which makes a big difference compared to the last owner."

People's views and that of their family members had not been sought regularly and we were not able to see how people using the service were involved in the running of the service. The last satisfaction survey was carried out in April 2017. Most of these were complimentary about the service and care people received. For example, one read, "Thank you for the wonderful care you gave to [relative]. You made [relatives] last 18 months a care free loving time. You all did a great job and thank you all for being a loving, caring and happy home." Another read, 'Suggestions for improvement; investment and refurbishment.'

Family members visiting relatives on the day of our visit were complimentary about the relaxed atmosphere at the service and the friendliness of the staff. One family member said, "I'm always welcome. I get a smile and sometimes a hug." A second told us, "We are always made to feel welcome here whenever we come."

We received positive feedback from three healthcare professionals about the service. They all agreed that there had been positive changes to the service and the provider was keen to work with them to improve people's care and support.

Overall staff felt supported and welcomed the changes the new provider had introduced. One told us, "Finally we have someone who is really interested. I feel positive about the changes and what the future holds." Another told us, "The new owner is here a lot. I feel I can go to them with any worries I have. They are approachable and willing to listen." However, some staff did not feel the registered manager was always approachable or that they were able to go to her with any concerns. One told us, "[Name of registered manager] does on-call but sometimes they can be a bit funny if you ring." Another member of staff commented, "You can go to the manager but you have to pick your moments." A third stated, "Sometimes I find it difficult to go to the manager. They are not always approachable and usually have their door shut. You never see [name of registered manager] on the floor. She is not visible or very supportive." During our visit we discovered that before the provider had taken over the service staff had not received regular one to one supervision to discuss their performance and any worries or concerns they may have had.

During this visit we found that the provider had been working with the registered manager to make changes to the culture of the service and to encourage an open line of communication with their staff team. For example, the provider was completing one to one supervisions for all staff in the first instance. They told us this would then be delegated to the registered manager and senior staff to complete on a regular basis. The registered manager's office had been moved to a more central location making them more visible to people, staff and visitors. The provider had booked further training for the registered manager and they had been

working with them on improvements to the service. In addition, there were also plans for the registered manager to have more support with creating a new deputy manager's post.

The provider and registered manager had upheld their legal responsibility by submitting notifications to the Care Quality Commission (CQC) of events which had taken place in the service, such accidents or incidents and deaths. Consistent with their legal responsibilities the provider had displayed the CQC rating from the previous inspection within the service 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not always been assessed and their safety monitored to ensure they were supported to stay safe while living at the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service needed to be strengthened and improved.