Lifestyle Care Management Ltd

Blenheim Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 4, 5 and 6 January 2017 and the first day was unannounced. The inspection was undertaken as a result of concerns received from the local authority. The previous inspection took place on 26, 27 and 28 April 2016 and the service was compliant, however we identified the completion of care records needed to improve and the registered manager had identified this for action.

Blenheim Care Centre provides accommodation for a maximum of 64 people. The service has three floors and accommodates people in single rooms each with en suite facilities. The ground floor provides general nursing care for up to 12 older people and 8 people with physical disabilities. The first floor provides personal care for up to 22 older people with dementia care needs. The second floor provides nursing care for up to 22 older people with dementia care needs. Each floor has communal dining, sitting rooms and bathing facilities. At the time of inspection there were 60 people using the service.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left in September 2016 and a new manager had been in post since 15 November 2016 and was applying for registration with the Care Quality Commission.

Risk assessments had not always been completed. Where risks had been identified, action to minimise them had not always been implemented, so risks to individuals had not been minimised.

Accidents and incidents had been recorded but they had not been investigated or reported to the local authority and there was no evidence they were being monitored to look for trends.

Repairs and replacement of equipment was not always carried out in a timely way, which could pose a risk to people's safety.

Staff recruitment procedures were in place but were not always being followed to ensure only suitable staff were employed by the service.

The service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Capacity and best interest assessments had not been carried out and consent was not always being sought for care and treatment, which could place people at risk of the service not acting in their best interest.

People's dietary needs and preferences were not always being identified and met and the quality of the food provision needed to be improved.

Care records did not always reflect people's individual needs, interests and wishes and there was no evidence that people and their representatives had not been involved in the planning of care.

Processes for auditing and monitoring had not been effective in identifying all shortfalls within the service.

The majority of staff responded well to people's needs and care and treatment was provided in a way that met people's individual preferences. People were treated with dignity and respect.

The provider made suitable arrangements to ensure service users were protected against the risks associated with the inappropriate administration of medicines.

Procedures were in place to safeguard people against the risk of abuse and staff understood the importance of keeping people safe and reporting concerns.

Moving and handling equipment was being used safely and correct procedures were being followed when transferring people and moving them around the service.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's healthcare needs were identified and they received the input they needed from health and social care professionals.

Some activities took place and work was ongoing to improve the activity provision in the service.

A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

The manager had identified shortfalls and was working with the deputy manager to make improvements at the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments had not always been completed. Where risks had been identified, action to minimise them had not always been implemented, so risks to individuals had not been minimised.

Accidents and incidents had been recorded but they had not been investigated or reported to the local authority and there was no evidence they were being monitored to look for trends.

Repairs and replacement of equipment were not always carried out in a timely way, which could pose a risk to people's safety.

Staff recruitment procedures were in place but were not always being followed to ensure only suitable staff were employed by the service.

Procedures were in place to safeguard people against the risk of abuse and staff understood the importance of keeping people safe and reporting concerns.

Moving and handling equipment was being used safely and correct procedures were being followed when transferring people and moving them around the service.

The provider made suitable arrangements to ensure service users were protected against the risks associated with the inappropriate administration of medicines.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

The service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Capacity and best interest assessments had not been carried out and consent was not always being sought for care and treatment, which could place people at risk of the service not acting in their best interest.

People's dietary needs and preferences were not always being identified and met and the quality of the food provision needed to be improved.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's healthcare needs were identified and they received the input they needed from health and social care professionals.

Is the service caring?

Good

The service was caring.

The majority of staff responded well to people's needs and care and treatment was provided in a way that met people's individual preferences.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

Care records did not always reflect people's individual needs, interests and wishes and there was no evidence that people and their representatives had been involved in the planning of care.

Some activities took place and work was ongoing to improve activity provision in the service.

A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

Processes for auditing and monitoring had not been effective in identifying shortfalls within the service.

The manager had been in post since 15 November 2016 and was working with the deputy manager to make improvements at the service.

Blenheim Care Centre

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.

This inspection took place on 4, 5 and 6 January 2017 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority who had raised concerns following their quality monitoring visit to the service in November 2016. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection team consisted of three inspectors, including a pharmacist inspector and a specialist advisor in mental health and dementia care.

During the inspection we viewed a variety of records including 10 people's care records, the medicine supplies and medicines administration record charts for 15 people, four staff recruitment files, risk assessments for safe working practices, servicing and maintenance records for equipment and the premises, safeguarding and complaints records, minutes of residents, relatives and staff meetings, audit and monitoring reports and policies and procedures.

We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the mealtime experience for people and interaction between people using the service and staff on all floors.

We spoke with nine people using the service, six relatives, the nominated individual on behalf of the provider, a peripatetic manager, the manager, the deputy manager, five registered nurses, 10 care staff including two senior carers, the activities coordinator, two catering staff, the maintenance person and one domestic staff member. We also spoke with two visiting healthcare professionals and an independent advocate.

Inadequate

Is the service safe?

Our findings

People's care records included risk assessments for areas that included falls, moving and handling, use of bed rails and nutrition. Staff reviewed the risk assessments monthly but in some cases the care records did not include sufficient, clear guidance for staff on how they should manage the risk. For example, one person's care plan included a history of falls but staff had not completed a falls risk assessment. There were bed rails fitted to the person's bed and these had not been removed or secured in the down position so they could not be used. The nurse told us that due to the risk of falls, "The bed must be at its lowest point and the rails removed. A crash mattress must also be used." These measures were not identified in the person's care plan. In addition there were two other people not requiring bedrails with unsecured bed rails in place. During the inspection the maintenance man took action to secure the bedrails in the down position for anyone for whom they were not to be used.

Equipment was not being replaced in a timely way at the service. We viewed the hairdressing room. One hairdryer was out of order and the second was missing a knob and the hairdresser was using a knife to turn it on and off. She stated this had been reported to the previous manager but no action had been taken. Food temperatures were taken and recorded before food was served. Records on one floor showed that food which fell below the recommended safe temperature stated on the record sheet had been served on a number of occasions. At the time of inspection food was served at the required temperature. The catering staff explained the temperature control for the hot food trolley was faulty and it was difficult to maintain the trolley at a stable temperature. Other comments regarding delays in replacing or repairing kitchen equipment were also received. We were told that supplies and menus had changed but consideration had not been given to preparation methods. For example, the new menu included toasted muffins, however there was no grill in the kitchen to do these on.

For people who required a hoist to be used for moving and handling, communal slings were being used and this had a risk of not being the correct size for a person and also presented a cross-infection risk through sharing slings. The nominated individual said the provider had instructed all of the managers to order individual slings for people some months previously, however it was apparent this had not been actioned.

The above paragraphs are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were being reported by staff, incident forms completed and entries made in the person's care records, so any such events were being recorded. However, injuries were not always being fully investigated or reported to the local authority. There were 16 accident/incident reports for December 2016.There were two incidents where people had sustained injuries and although these had been recorded and statements obtained, the statements did not identify clearly how the injuries had been sustained and no further investigation had taken place. For one person there was a statement on the incident form and two staff had written their views on what had happened and included a written difference of opinion in respect of the staff present on the unit at the time of the incident. One person had hit their head and neurological observations had been carried out for six hours following the incident, but the person did not

see the GP for three days and there was no explanation why medical input had not been sought at the time of the incident. Three minor unexplained injuries had been recorded but not investigated. The deputy manager provided an explanation for one, however this information was not recorded anywhere. For another person who had been found on the floor there were some discrepancies in the information provided by staff that had not been followed up. The incident forms did not include a prompt for staff to contact the local authority to report incidents and accidents. We asked the deputy manager to ensure all incidents were reported to the local authority. We checked with the local authority following the inspection and found the incidents and accidents had been reported to them two weeks after the inspection.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were in place but had not always been followed to ensure only suitable staff were employed at the service. Application forms had been completed. For one staff member there was a gap in employment and no explanation for this had been recorded, also there was no place of work stated to identify where one referee had previously worked with them. For another, only one reference was available and the second reference request had not been followed up. On a third form, we saw there was a discrepancy between employment dates stated on the application form and those on the reference. This had been identified on the file however it had not been followed up with the staff member until after it was identified at the inspection.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed they had gone through the recruitment process prior to working at the service. One told us, "Before I started here, they did a police check and I had to give two referees." Criminal record checks such as Disclosure and Barring Service (DBS) checks, proof of identity documents including passports and information regarding staff members' right to work in the UK were available. For nurses, information about their qualifications and evidence that they were currently registered to practice with the Nursing and Midwifery Council and expiry dates of their personal identification numbers (PIN) was available. A photograph was seen on one file, with others containing copies of the passport page with a photograph. Information regarding the fitness of staff to work at the service was not seen. The nominated individual told us health questionnaires were sent out by and screened at head office and any relevant issues were passed onto the home managers. This information was not in the recruitment policy and we were told this had already been identified with the provider who was taking action to address it.

People told us that they felt safe at the service. Comments included, "I feel safe and comfortable here. I am very happy and comfortable and the staff make me feel safe", "My family didn't think I was safe at home so they are happy I'm here, they know I'm safe" and "There is nothing I don't like about the place, the staff look after me day and night and they always respond promptly when I ring the call bell. I have got this barrier that stops other people from getting in my room." Relatives said they felt their family members were safe. One said, "A few weeks ago I honestly believed that the life of my [family member] was coming to an end, she had lost a lot of weight. Coming here has made a big difference. She is now alive and very safe and the staff are excellent."

There were sufficient numbers of staff on duty to meet people's care needs on the days of the inspection. However, the staff told us they were often short staffed and agency staff were often employed at night and the weekends, which was evidenced on the staff rotas. During the inspection there was a day when senior staff had to cover for care staff who were absent at short notice, which meant supernumerary time for

reviewing care records was forfeited. Staff responded promptly to call bells and people were not kept waiting for care and support. People's comments included, "There are usually enough staff. You don't have to wait long for somebody to come" and "My usual carer is very good but they are always changing and new staff don't always know what help I need." Staff told us, "The team work is good, it's important we work together", "There are enough staff but we are always busy, there is always something to do", "I feel part of a good team, we all help each other", "There are enough staff if everybody is in but the team leader sometimes has to cover", "The team work is good but it can be very busy, especially if someone is off", "When we are short we get help from the other floors" and "When we are short and can't get help we work twice as hard and don't leave until the job gets done and this means working after hours. We always make sure people are safe" One nurse told us, "I help the carers when we are short."

Staff knew the action to take to protect people from abuse and keep them safe. The provider had a policy for safeguarding adults and it included information on what constituted abuse and guidance for staff on action they should take. Staff told us they had completed safeguarding training. We gave them different safeguarding scenarios and they knew the action to take. Their comments included, "I would tell the senior or deputy manager" and "I'd tell someone in charge." We also asked staff about whistle blowing and they knew they could report concerns to outside agencies if managers did not take action to keep people safe. One member of staff said, "I have been doing this job for a long time. I am here because I enjoy caring for the weak and elderly, they are like my own mothers. If there is abuse and nothing is done about it, I shall call the local authority. Their numbers are on the notice board." Telephone numbers for the local authority and other services were listed in the offices on each floor and staff knew where to access them.

We viewed the safeguarding records and saw there were three currently being investigated and six others had been closed by the local authority at the alert stage and were not being progressed. The manager and deputy manager knew to report any safeguarding concerns to the local authority. We discussed ensuring accidents and incidents were also reported, where appropriate, to the local authority so they could review them to ensure there were no elements of safeguarding involved.

Records for the servicing and maintenance of equipment were available, including passenger lifts, portable appliance testing, gas appliances, servicing of hoists and adjustable baths and weighing scales. Records for periodic checks such as the nurse call system, the fire alarm, and temperature checks of hot and cold water outlets to ensure these were maintained within safe range were available. We observed staff supporting people to move around the service safely. Equipment including hoists and wheelchairs were used to move people and moving and handling procedures were being followed. On the second day of inspection the deputy manager and nurses had assessed each person who required a hoist for moving and handling for a sling and these were then ordered so people would have their own sling for use.

The fire risk assessment had been completed and an action plan put in place with the person responsible for actioning each area identified. All actions were to be completed by October 2017 and some areas had already been completed. There were Personal Emergency Evacuation Plans (PEEPs) in place and a fire evacuation dependency risk form to identify the input each person would need in the event of evacuating the service. There was also an emergency contingency plan in place should people have to be evacuated from the service and this identified places where people could be transferred in such an emergency. Regular fire drills took place and where shortfalls were identified, action was taken to address them. Risk assessments for premises, equipment and safe working practices were in place and had been updated during 2016 to keep the information current.

We checked medicines storage, medicines administration record (MAR) charts and medicines supplies. All prescribed medicines were available at the service and were stored securely in locked medicines cupboards

within each treatment room. Current fridge temperatures were taken each day including minimum and maximum temperatures. During the inspection and observing past records, the fridge temperature was found to be in the appropriate range of 2-8°C. This meant medicines were available for people and were being stored correctly. People received their medicines as prescribed, including controlled drugs. On the medicine administration record (MAR) charts we viewed there were no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate MAR charts for people who had topical medicines prescribed to them, such as creams. These were filled out and showed the site of application on a daily basis by carers. However, we found that staff had not signed to indicate they had transcribed the instructions from the prescription/MAR and there were no countersignatures.

One person confirmed they received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the client. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this, in line with national guidance. Medicines to be disposed of were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities completed by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw minimal sedatives that were prescribed for people with dementia in order to control behaviour. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

Medicines were administered by nurses or senior carers who had been trained in medicines administration. We observed a member of staff giving medicines to a person and found that staff had a caring attitude towards the administration of medicines for people. We looked at five MARs for people who were administered their medicines covertly. We found that he/she had the appropriate authorisation and input from professionals to enable them to have their medicines covertly. For example, there was evidence of a medicines form which was signed by the GP and the pharmacist. This assured us that people in this location were administered medicines covertly in an appropriate manner in accordance with legislation and recommended guidance.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider, including safe storage of medicines, room and fridge temperatures and stock quantities checked on a daily basis. Staff stated that no medicines incidents/near misses had been reported recently. They demonstrated the correct process verbally of what to do should an incident/near miss arise in the future, including who to contact. This was in line with the provider's policy.

Senior staff were satisfied that they had a positive working relationship with the responsible GP but they were not happy with the arrangement with the supplying community pharmacy. They felt that the provider did not receive good support with regards to the training of nursing staff or the delivery of monthly medicines three days before the new cycle was due to start. This meant there was a risk that medicines could be delayed to people should there be any discrepancies between the prescriptions from the surgery and delivered medicines by the pharmacy. However, we did not find evidence during the inspection of

people having their medicines delayed during the monthly cycle and the deputy manager told us that this risk was mitigated by checking the medicines that were to be received a week prior with the supplying pharmacy. We found that people obtained a review of their medicines when needed and this was evidenced by checking the record of several medicines reviews that had been carried out by the GP within the last month.

Requires Improvement

Is the service effective?

Our findings

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care and treatment was not always provided in a way that respected people's rights. Apart from in one record viewed, care records did not contain capacity assessments of people's ability to make decisions by themselves, best interest decisions or consent having been sought and provided. For example, staff completed risk assessments for bed rails but there were no consent or to the use of rails where these were identified as being necessary. Care records included a general consent form for the use of photographs, outings and the administration of medicines but the majority of those viewed were not signed by the person concerned. Where people had capacity or a relative had lasting Power of Attorney for health and welfare, there was no evidence that they had been involved in the care planning process and none of the care records viewed had been signed by the person or, where appropriate, their representative.

For one person there was no evidence staff had spoken with the person's family or the GP about the need for a Do Not Attempt Resuscitation (DNAR) decision, although the care plan said this was 'needed urgently'. Staff had received training in MCA, however some did not demonstrate a good knowledge of allowing people choices and acting in their best interests. On one floor people were not encouraged to make simple decisions such as choosing their own clothes, meal and drink choices and to participate in their personal care. When asked if people were encouraged to wash themselves one staff member said, "No, we do everything for the person." During the lunch we heard staff say "I am putting a bib to protect your clothes" as they placed the protective aprons around people's necks, which was an infantilising use of language. Although there were a variety of drinks available staff on this floor did not offer people choices.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a file of DoLS applications and authorisations and copies were also seen in some people's care records, however where there were conditions in place on the authorisations this had not been reflected in the care records. We went through the DoLS authorisations with the deputy manager and she was able to tell us where conditions had been met and said she would ensure these were all reflected in people's care plans. We did see a comment in one person's care record that said, "Ask for consent before beginning personal care." This demonstrated some staff were aware of the need to ensure people consented to their care.

Some people were not happy with the food provided in the service. Their comments included, "I don't really enjoy the food but I can have bacon and eggs and cheese on toast," "The best word to describe the food is bland" and "The only word to describe the food is awful. It is tasteless and the vegetables are not cooked properly." On one day of inspection we looked at and tasted the lunchtime meal. The fish was hard and the chips were dark brown and tasteless.

Meal times were protected and all staff were available to assist with meals. Two people said they were happy with the food. The relatives said that although the quality of the food was good it did not meet the cultural needs and preferences of the people. One relative told us, "My [family member] likes curry and halal food and this is not always available. So as a compromise my [family member] has vegetarian meals and I prepare halal meals from home whenever I can." Another relative said, "My [family member] loves West Indian food, but this is not available. The staff have given me the option of bringing West Indian food from home. My [family member] is not a fussy eater, so he normally eats what is available." Therefore, the food provided did not always reflect people's choice or preferences.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was food of differing textures to meet people's needs, for example, normal texture, soft food and puréed food. Care records showed that speech and language therapists had assessed people's eating and drinking needs and dieticians had been involved to ensure their nutritional needs were identified. There were a variety of cold and hot drinks served to people throughout the day including to those who were in bed, to maintain their hydration. People could eat in the dining rooms, the lounges or in their bedrooms. Staff were available to assist people with meals. We saw staff sat with people when providing assistance and did not rush them. They also offer words of encouragement. The service encouraged participation from relatives at meal times. One relative said, "I come to feed my [family member] every day because I like to and not because I think that I can do a better job than the staff, because I think the staff do a fantastic job." Staff were aware of people's nutritional needs and followed guidance for eating and drinking in place for people. This meant that people were supported to have a balanced diet and eat healthily.

People commented positively on the staff who cared for them. Their comments included, "You can't fault the carers, they are angels. We have a chat and a laugh", "The staff are alright, they feed me", "Overall? It's not too bad. I get the help I need" and "It's all hunky dory, I'm well looked after and I get my meals." Comments from relatives included, "My [family member's] care is very good. So they must be well trained" and "I think they are well trained because the care my [family member] receives day in and day out is very good and they are very professional in their approach."

Staff said they had completed all of their mandatory training. They said this was mostly e-learning but they had practical training for moving and handling and medicines management. Their comments included, "My training is up to date but I know I am due some refresher training shortly" and "I have done all my training." Staff also told us they felt well supported by senior staff in the service. Their comments included, "I have supervision with [team leader]. I feel they understand my job and they listen to me" and "I have supervision and it is useful. I think all the senior staff are very supportive." Some staff said they had received regular supervision and others were unsure, with dates varying from four to six months between supervisions. There was a schedule of supervisions and this recorded that staff supervision was planned and the deputy manager said she was working on this to ensure all staff had regular supervision sessions.

People received input from healthcare professionals to ensure their health needs were met. One relative told us, "My [family member] sees the GP regularly and the staff contact them and me when she needs to be

seen in emergency." A member of staff said, "The GP visits weekly and we can get in touch with them by phone and in emergencies." We saw that for people with diabetes, they had regular eye checks and visits by the chiropodist. The diabetic care nurse and the GP were also involved in the management of their diabetes. Records also showed involvement of the dentist, physiotherapist and occupational therapist. People's care records included information about their health care needs and how staff in the service met these. We saw evidence of joint work with healthcare professionals including GP's, opticians, dentists, chiropodists, speech and language therapist, dietitian and hospital clinics.

Where people needed specialist support, this was provided. A support worker for the local Stroke Association told us they had received a referral from the hospital shortly after a person was discharged to the service. They told us it had been easy to make an appointment to meet with staff and the person to discuss their care and support needs. They described staff as welcoming and said they were interested in hearing about the specialist support that was available for the person. We spoke with two healthcare professionals who provided input to people using the service. They said people were referred to them appropriately and one said staff anticipated people's care needs.

Good

Is the service caring?

Our findings

Most people told us that staff were kind and caring. Their comments included, "The staff are very good, very kind" and "The staff are caring, they do a good job." However, one person told us, "It is very annoying when staff chat away in their own language, they should speak English when they are with me in my room." Relatives told us the support provided for people was "excellent" and staff were caring and respectful. Comments included, "The staff are nice and patient", "They are kind and caring", "This is the nicest home [family member] has been in. They are all very smiley here" and "I find the care very good and the staff very friendly and approachable. I trust them with my [family member] because they care and do it to our satisfaction." During the inspection we saw staff interacted positively with people. They chatted with them in the communal areas, there was laughter and staff showed patience and supported people in an encouraging and gentle manner. We saw staff also listened to people who sometimes needed time to explain what they wanted.

Staff we spoke with told us that people using the service were the most important thing. Their comments included, "Little things make a difference. I can spend five minutes talking to someone or fifteen minutes painting their nails and it can make someone's day", "The best thing about working here is the people we look after. It is the most satisfying job I have ever had", "It's very satisfying when you can help someone and make them smile", "I can make a difference to someone's life every day here" and "I love my residents, it is the best job in the world, helping people." People's care records included guidance for staff on treating people with respect and dignity. We saw staff supported people with their personal care in private and always placed a sign on the person's bedroom door while they supported them to ensure they were not disturbed. Guidance in people's care records included, "Respect her choices," "Respect her privacy and dignity at all times" and "Provide privacy and dignity at all times."

We used the Short Observational Framework for Inspection (SOFI) to observe people's experiences at lunchtime on one floor. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. The SOFI observation showed that people had a positive experience. They did not wait for support, staff offered choices and where people needed support to eat or drink, staff provided this in a patient and caring way. Staff sat next to people when they assisted them and carried on a conversation with them throughout the meal. There was a good dining environment and tables were laid with table cloths, napkins, drinking glasses and condiments. Staff responded well to people's needs to maintain a calm atmosphere. On one occasion when a person with potential to show behaviours which might challenge others asked to visit the toilet, staff responded promptly and calmly. In another situation when a person was restless and shouting, staff took them to a quieter environment where the person was more comfortable and others would not be disturbed.

We saw staff approach people in a respectable manner. This was described by one relative who said, "You will notice that the younger staff always addressed my [family member] as 'Maa'. This is a respectful way of addressing an elderly person in our culture." When speaking with people staff always got near them and maintained eye contact. In one instance we observed a member of staff kneeling down in order to ensure eye contact. Staff always knocked on bedroom doors before entering. Staff were aware of people's

communication needs. For example, for one person staff were using a board with pictures plus words in the person's own language in order to communicate with a non-English speaking person. One staff member told us, "I always tell a person about the actions I am about to carry out before providing personal care in order that people knew what was going to happen." Relatives told us that there were no restrictions on visiting times. One relative told me "I can see my mother when it suits me best." We arrived at 08.25 on the second morning of inspection and observed staff greeting people in a polite way. Where medicines were being administered we saw the nurse checked people if they were ready for their medicines and also asked 'how was your night?' Staff were polite, interacted well with people and responded to requests for assistance promptly. During breakfast one person did not start their meal and a member of staff came in and asked them if they wanted to go to their 'usual lounge' to which the person said 'yes' and the member of staff took them. Staff were attentive and went around to check with people in their rooms what they would like for breakfast, which they then provided.

Requires Improvement

Is the service responsive?

Our findings

Care records did not always identify the help and care people needed so they were at risk of not having their needs met. Pre-admission assessments were carried out prior to people coming to live at the service, however the information on these was either not completed or partially completed. For example, the pre-admission process did not identify whether people preferred to be looked after and assisted by male or female staff and in particular during personal care. This led to a female being attended to by male carers during personal care. The staff placed a notice on their wall wall to indicate they preferred female staff. The same situation arose several months later when another female was given personal care by a male member of staff. Although relatives were happy they had been able to speak with staff straight away and there had been no repeat of the incidents, the service had not learned from the first incident. People's religious and cultural needs were not always respected. The service did not assess people's dietary requirements according to their religious and cultural needs during pre-admission. They did not provide for this and depended on relatives to meet this need.

People's care records were detailed and it was not always easy to easily identify a person's specific care needs from the records. The care plans covered people health and social care needs, including skin care, nutrition, medicines management, personal care, continence, social, religious and cultural needs. However, three of the care records were lacking information and guidance for nursing and care staff. For example, no information for social, religious and cultural needs and very brief life history information. Incomplete 'all about me' booklets, which were designed to contain important information about the person to go with them if they went to hospital. Records contained a 'care needs summary' document and the notes stated that the summary was 'an invaluable at a glance overview of the key considerations that underpin each resident's individual care'. However, these were not always completed so the information was not being provided to staff in an accessible way. Records did not contain signatures of the person or where appropriate their representatives to evidence they had been involved with the care planning process from assessment, care planning and evaluation. Monthly reviews of the care records had not picked up on those shortfalls.

Staff encouraged people to take adequate fluids but did not know the average daily intake each person should have. Staff completed food and fluid charts for specific people where they had identified a need to monitor the amount they ate and drank. People were offered a variety of hot and cold drinks throughout the day and there were jugs of water and juice in people's rooms. People in bed were offered drinks and were supported by staff. Where care records indicated the amount of fluid a person should consume in 24 hours, the information had not been transferred onto the fluid charts so carers were unaware of how much fluid individuals needed daily. The total amount people drank was not always recorded and some charts indicated people drank very little during the day and went for long periods between drinks. There were no signs that people were dehydrated, however there was a risk of this due to records not always being accurately completed.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked a carer how they supported a person they hadn't worked with before they told us, "The care plan is too long to read. I would ask another carer, the senior or the person themselves what help they need." A second carer said, "The only thing I would improve is the care plans, they are too long and it is hard to work out easily what help someone really needs." On the first day of inspection one member of staff said, "I am supernumerary today and I am assigned to bring the care records up to date."

In some people's records we saw documents including a clear life history, their likes and dislikes and preferred morning and night time routines and care, clear guidance on supporting the person with personal care and skin care. a nutritional care plan and weight record, clear guidance for care staff on promoting mobility and a good assessment of the person's hobbies and interests. Care staff completed daily care notes for each person. These tended to focus on the practical care tasks they completed and were mainly related to personal care, continence or nutrition. We saw few mentions of social activities, outings or visitors.

People were protected from the risk of developing pressure ulcers. A person's records specified they should be supported to turn over in bed to relieve pressure on their skin. They were supported to do so every two hours. Staff had signed a chart to confirm that they had done this. We observed that one person with pressure ulcers had been turned two hourly to change their position. The air pressure in the mattresses were checked and recorded daily. For one person wound care documentation had been appropriately completed and showed that the wound had healed. Their relative told us, "My [family member] skin has healed completely thanks to the effort by the staff. They changed and turned him regularly. His dressings were always done. I can't thank them enough." A nurse knew how to obtain advice about the prevention and management of pressure wounds from the tissue viability nurse specialist should this be required. This was demonstrated in another care record of a person with pressure wounds. The nurse had obtained input from the tissue viability nurse specialist and had incorporated the advice into the management of their care.

Most people had their personal care attended to and were well dressed by breakfast time. The rooms were clean and tidy and there were no hazards. The care plan provided information about the number of staff required to hoist people and the number of staff required to assist people in carrying out their personal care. Staff said that when giving care they ensured they had the right number of staff to assist in hoisting and assist in giving personal care. Only one staff mentioned that she explained the care before delivering it. This was also reflected in the care records and care plans did not all include the wishes and preferences of the people. The care staff said they did not read the care plans prior to delivering care. One carer told us, "We know how to give care because we have done it many times."

Some people told us they did not enjoy the social activities organised in the service. Their comments included, "There's never anything happening is there? I read my books and the paper and watch TV," "I keep to myself. There aren't any activities here I enjoy" and "There are no activities that interest me. I don't want to spend time in a room where half the people are asleep. We saw there was a monthly programme of activities that was displayed around the service. During the inspection we saw small groups of people took part in art and craft activities and a sing-a-long session which they enjoyed. We asked staff about activities and comments included, "The activity will not be taking place because the activity coordinator is sick", "We joined in the activities when they are organised by the activity coordinator, but we don't have time to do activities with the people" and "I would be telling a lie if I said that I run activities and I encourage people to take part in their hobbies. I have too much on my plate."

We spoke with the activities coordinator on the second day of inspection. She had been in post for six weeks and had been reviewing the activities provision in the service. She told us that she spent time with people who stayed in their rooms so that they received some one-to-one input. We noted that for several people the life history section of the care records was incomplete and the activities coordinator said she had already

identified this, which we saw on the list she had to hand. She said she would be completing these with people and, where appropriate, their relatives to gain information about their lives and interests. The activities coordinator had a weekly activities programme which she gave out to people during the inspection and spoke with people about. There was a wide range of ages and abilities within the service and the activities did not cater for everyone, however with more information about people the activities coordinator hoped to improve on this and said she had also expressed interest to the deputy manager for training specific to her role.

People using the service told us they knew how to make a complaint and felt the provider would address any issues they raised. Their comments included, "I'd speak up if I had any complaints" and "I'd speak to [the deputy manager] if I had any complaints." Relatives knew how to make a complaint and said they were satisfied that complaints would be investigated and acted upon by the service. One relative said, "The only complaints I have is that the staff are too kind." Relatives said they attended meetings where they had been able to air their views and also if they have any concerns they know that these would be addressed. The provider had a complaints policy and procedures they had reviewed and updated in December 2015. The provider recorded complaints they received from people using the service, their relatives and other visitors. The record included details of the actions the provider took to investigate the complaint and copies of letters sent to the complainant following the investigation.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place for monitoring the service, however these were not effective. During our inspection we identified shortfalls in several areas. These included staff recruitment, accident and incident reporting, risk assessment, bedrail use, maintenance and replacement of equipment, monitoring of care records and person-centred care giving. The auditing and monitoring processes were not robust and so shortfalls were not always being identified and addressed, which placed people at risk.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nominated individual and peripatetic manager took action during the inspection to instigate repairs, however it should not have taken a Care Quality Commission (CQC) inspection to identify the shortfalls. In-house audits were carried out monthly and these included condition of pillows, bedrails, falls, skin tears, pressure relieving equipment, infection monitoring, pressure ulcers and weight loss. Although these were being kept up to date to identify any issues, they had not identified issues such as ensuring bedrails were appropriately managed. Quality monitoring visits on behalf of the provider had been carried out in October and December 2016 and these identified some of the issues identified in this report, however work was required to address them. The manager had completed the action plan for the December 2016 report and included completion dates to meet the requirements set.

The provider involved people using the service, their relatives and representatives and staff in the running of the home. We saw detailed minutes of a meeting for people using the service and their relative the provider held in September 2016. The meeting discussed a wide range of issues, including complaints about the food provided, the decor of the service, the lack of equipment, staff changes and retention and the attitude of a small number of staff that some relatives felt was not caring. Following the meeting, the provider had drawn up an action plan to address the concerns people raised about the catering, staffing, training, retention of staff, maintenance and medicines management.

We also saw the record of a staff meeting held in October 2016 where staff raised a number of concerns. There was some evidence the provider had responded to some of the issues raised. For example, some refurbishment and redecoration works had been completed and the provider had introduced increased monitoring of new nurses when they began to administer people's medicines. We saw the deputy manager had been auditing a selection of care records and they had identified shortfalls but it was not clear who would be responsible for updating the records.

Relatives said they had met the manager and felt she was approachable. Two relatives had attended a meeting chaired by the manager. One relative said, "It reassures me to know that I can go to the manager directly with any concerns. The manager told me that she adopts an open door policy as far as the relatives are concerned." Another relative told us, "They are approachable and [manager] does her best." Two staff said the manager had told them that they should not approach her directly and that if they have any issues they should go through the hierarchy.

The manager had been in post since 15 November 2016. She was an experienced manager and was a registered nurse and had a management qualification. She had identified areas of work and we saw there had been improvements since she had started in post, for example, following up safeguarding alerts with the local authority, recruiting permanent staff and working with staff to complete their training, thus improving the provision and completion of staff training. She said she encouraged people and relatives to raise any issues so they could be addressed.

A member of staff said, "We have 'flash' meetings every morning chaired by the manager where clinical matters are discussed and lessons learnt from incidents." We sat in on one of these meetings and it was attended by the manager, deputy manager and the nurse/senior in charge on each floor. They covered points raised by the inspection as well as discussing the day to day issues for each floor and how these were being addressed. Additional areas for maintenance were identified including a microwave oven that was not working and a replacement was purchased at the time of the inspection. Issues with the hot water urns were also being reported to be addressed. Heads of departments such as catering, housekeeping and maintenance were not included in these meetings, so they were not provided with a daily opportunity to report or follow up on any issues or repairs required. We discussed this with the peripatetic manager who confirmed all heads of department should be included in the meetings and said she would address this with the manager.

Notifications were being submitted to the CQC for notifiable incidents such as deaths, safeguarding concerns and serious incidents, however we identified that the required notifications had not been submitted for all the people for whom DoLS authorisations were in place. We discussed this with the deputy manager who said she would address it.

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 The registered person did not: 1. Carry out adequate assessments of the needs and preferences of service users. 2. Design care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9(1) and 9(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent from the relevant person to agree to care and treatment of service users was not obtained. Regulation 11(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 registered person did not: 1. Assess the risks to the health and safety of service users of receiving the care or treatment. 2. Do all that is reasonably practicable to mitigate any such risks. 3. Ensure that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used

	in a safe way Regulation 12(a)(b)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good Governance The registered person did not: 1. Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. 2. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 3. Maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not operate recruitment procedures effectively to ensure the required information was obtained for people employed at the service Regulation 19(2)(3)(a) and Schedule 3