HC-One Limited

Tower Bridge Care Centre

Inspection report

1 Tower Bridge Road,
London,
SE1 4TR
Tel: 020 7394 6840
Website: www.hc-one.co.uk

Date of inspection visit: 18 and 23 November 2015
Date of publication: 10/03/2016

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 18 and 23 November 2016 and was unannounced.

Tower Bridge Care Centre is a home registered to provide accommodation, nursing and personal care for up to 128 people. Some of the people who live at the home have dementia. At the time of our inspection, 75 people lived at the home.

A manager had been recruited and her application to be registered with the Care Quality Commission had been submitted and our assessment was underway at the time of the inspection. The manager was registered in early January 2016. 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 last comprehensive inspection of this service was in June 2015 and a follow up inspection was carried out in August 2015. At the last comprehensive inspection, the provider was placed into special measures by CQC. This inspection in November 2015 found that there was enough improvement to take the provider out of special

Summary of findings

measures. We found improvements compared to our visits in June and August 2015. In particular, we found improvements in the way medicines were managed. We also found that care was delivered in line with advice from specialists, particularly in relation to pressure ulcer care, nutrition and hydration. Previous requirements relating to those areas of care were met. We also found the new management team had established processes to assess monitor and improve the quality and safety of the service.

We found three breaches of regulation at this inspection. We found not all risk assessments were clear or in place and so people and staff were potentially at risk of harm because staff did not have appropriate guidance. We have made a recommendation about the frequency of formal supervision for staff. We found two breaches of regulations which were repeated from our last inspection in June 2015. We found that people did not always receive care when they wished because staff were not always available. We also found the provider did not monitor the quality and safety of the service when there was no manager in place.

Staff were knowledgeable about abuse and the manager had taken prompt action when allegations were made to ensure they were investigated. Medicines were managed safely and this was an improvement on previous inspection findings. Safe recruitment practices were followed.

People were given assistance with meals when they needed it but the records were not adequately detailed to monitor their preferences. Records of other care tasks were not always kept and we could not be sure they had been carried out.

The manager and staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The manager made applications to protect people under DoLS when this was judged appropriate and improvements were being made in relation to assessments of people's capacity to consent and holding 'best interests' meetings.

We saw many instances of staff being kind and caring to people but we saw a minority of staff were not. We saw two instances where staff who helped people with meals were disrespectful and inconsiderate. One of these staff members raised their voice while assisting the person. The second staff member did not inform the person what the meal was, and did not look at them so they could assess their reaction and needs in relation to the meal. In other situations we saw that people's dignity was respected.

People and their relatives did not always have the opportunity to contribute to care records and plans so they did not adequately reflect people's wishes and needs about their care. There were activities provided but they did not always reflect people's recorded wishes and interests, and in some cases these were not recorded.

Staff did not always work well together to benefit the people who lived at the home and a sense of teamwork was not always present. The manager had introduced quality audits with a view to making improvements. These included making spot checks on the home at night time to make sure that staff provided effective care at all times. She was proactive in addressing problems.

Summary of findings

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. Sometimes too few staff were available for people to rise from bed when they wished.

Staff had not always completed assessments to manage situations that put people at risk.

Staff were knowledgeable about abuse and the manager dealt with allegations of abuse promptly to protect people.

Medicines were well managed so people received their medicines when they needed them.

The provider made appropriate checks of staff before they began work at the home to make sure they were suitable to work with people.

Is the service effective?

Requires improvement

The service was not effective. Staff felt supported by managers but they did not receive formal supervision frequently enough to make sure their on-going competence was assessed.

Staff assisted people with meals and generally this was helpful. We observed some situations when staff did not support people appropriately.

The manager was familiar with how they should support people in line with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). They were introducing changes to make sure mental capacity assessments were improved. People were asked for their consent to care and support when they were able to give it.

Staff contacted health care professionals and their advice was used to improve people's care.

Is the service caring?

Requires improvement

The service was not always caring. We observed that a worker raised their voice when assisting a person with a meal. Other staff recognised this was wrong and took action to stop it happening.

We saw and heard about examples of staff being kind, caring and respectful.

Staff took time to chat with people, and helped them do things they enjoyed.

Is the service responsive?

Requires improvement

The service was not always responsive. Care records did not always include people's and their relatives' views. When people's preferences about activities were recorded, they were not always provided.

Summary of findings

People and their relatives knew how to complain. When they did so the manager investigated their concerns.

We saw people enjoying a tea party which was a new development at the home. People had opportunities to follow their religion.

Is the service well-led?

Requires improvement

The service was not well led. There had been a period of instability in the management of the home and the provider had not monitored the home sufficiently in this period. Relations between staff were not always positive and this affected the ability of the staff team to provide good care.

A new manager began work in August 2015 and was working with colleagues to address areas of weakness in the home. They carried out audits and checks to identify priorities.

Notifications to the Care Quality Commission were made as required. The provider worked in partnership with organisations involved with people living in the home with a view to improving care.

Tower Bridge 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 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 18 and 23 November 2015 and was unannounced. The inspection team was made up of three inspectors, an inspection manager, a pharmacy inspector, a specialist advisor who was a nurse 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. Their area of expertise was in dementia care.

Before the inspection we contacted to the safeguarding and commissioning teams from the local authority. We also reviewed the information we held about the service, including notifications received. A notification is information about important events, which the service is required to send us by law.

During the inspection we spoke with 12 people that used the service and 7 relatives. We reviewed 15 people's care records. We spoke with 16 staff including members of the management team, nurses, care assistants and members of the ancillary team. We also spoke with two professionals who were visiting when we were there and with one professional after the inspection.

We reviewed medicine management on all floors of the home. We reviewed three staffing records including staff recruitment. We reviewed management records including audits, incident records, safeguarding records and complaints.

We undertook general observations and used the short observational framework for inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection we asked the manager to send us copies of the minutes of meetings held for people living at the home and their relatives but we did not receive them.

Requires improvement

Is the service safe?

Our findings

At our previous inspections in June and August 2015 we found the service was not safe and was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not managed safely. Medicines were not stored appropriately, adequate stocks were not available and medicines were not administered as prescribed. At this inspection, we found that the provider had made improvements.

We found people received their medicines, including controlled drugs, as they were prescribed. We found no discrepancies in the recording of medicines administered. A person who reported that they received their medicines in a correct manner confirmed this. The manager and permanent nursing staff acknowledged that agency nursing staff increased the risk that people may not receive their medicines as prescribed.The manager said that they had regular audits and enhanced induction training to ensure that all staff were competent in administering medicines. The provider followed current and relevant professional guidance about the management and review of medicines. Medicines audits were undertaken on a monthly basis, which was an improvement on previous inspections. These showed good governance processes as they fed back into a system of reporting stock levels and medicines errors.

Medicines were stored safely in locked trolleys in locked rooms. People received their medicines in a safe and caring manner, using appropriate hygiene techniques. People who initially refused to take a medicine were re-offered the same medicine a short while later. Any medicines which required disposal were placed in the appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a private contractor.

The service protected people from the misuse of these medicines. This was evidenced by protocol forms for medicines given 'as required' for pain-relief and anxiety. A member of staff we spoke with was knowledgeable about the circumstances in which these medicines could be given. There were written procedures which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have the intended benefit.

Staff were competent to administer medicines in a safe and effective way. Members of the staff demonstrated practical knowledge about people's individual preferences and needs regarding their medicines. For example, a staff member told us that a person preferred to take their medicine in their bedroom, and any change may cause them to become distressed.

At the inspection in November 2015 we were concerned that people's wishes and needs about when they received care were not always met because there were too few staff available to provide care when they preferred or needed to receive it. One person told us they got up at 5am. They said they chose to get up early and their choice was made so they could get help from care staff with washing and dressing. They said, later than that the carers were busy, would not have time to help them and they would have to wait for assistance.

Visitors were aware of the impact of staffing levels on their relatives. A relative told us "There is a lack of carers". Another relative said, "They [staff] are run off their feet. They haven't got enough staff." A third visitor told us on our first visit they had arrived at 9.40am and found their relative was in bed and had not been assisted to be washed, dressed and changed. When they asked a carer for help they had said "sorry, we're short staffed". This meant that care tasks were delayed.

Staff told us, they did their best to manage despite staffing levels which were sometimes lower than planned due to sickness. One day in the week prior to our visits there had been only one nurse and one care worker to look after 16 people living in one unit, instead of three care workers working with a nurse. Two care workers had not arrived for work and this had caused the shortage. Senior staff requested for agency staff to be sent they did not arrived to work at 11am. A care worker told us the situation "was difficult but we managed" and people who would usually be assisted by day staff to get up and ready for the day had to remain in bed against their wishes and usual routine because too few staff were available to assist them.

Staff told us there was a high use of agency staff who were unfamiliar with people's needs and this increased the pressure on permanent staff. One staff member told us that on approximately three days a week they had to spend time telling agency carers what to do and then supervise them. They said this was very time consuming and put extra pressure on permanent staff. A relative said they knew

Requires improvement

Is the service safe?

the high use of agency staff was difficult and felt "The permanent staff are overworked." Another relative said, "When we have our own staff it [the home] runs well, but it's the agency staff [that make things difficult]." A person living in the home said the changes in the staff team were difficult. They said about the temporary staff "you get used to them and then they go."

People were restricted in their activities by the number of staff available to care for them. On each floor of the home lounges at the ends of the units were empty and people frequently sat in chairs in the corridors often near the floors' reception areas where staff were attending to records. We observed that people enjoyed watching in these areas, but found staffing levels meant staff were not available to sit elsewhere with people. A member of staff explained to us that people were not encouraged to use the lounges so they could be sure of people's safety. The staff member said, "I haven't got enough staff to sit with them [people] in the lounge, at least they can be seen from the reception".

This was a breach of regulation 9(1) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The assessment and management of risks did not always protect people and staff. In a meeting between staff, we heard about a person whose behaviour was challenging when they were distressed and could have put people and staff at risk. Staff told us that usually two and occasionally three care staff assisted the person with their personal care. The person's care record confirmed what staff told us but did not include a risk assessment of how to manage situations when this occurred or recommended action to take to assist with the person's distress. Staff had told us about an incident that had occurred on the morning of our first visit to the home and said this was a frequent occurrence. There was a chart for recording details of incidents of the person being distressed. There was only one entry on the chart, which was made in October 2015 and the chart did not reflect the other incidents which were recorded in the person's daily notes. These records, if maintained consistently, could have assisted staff and health care professionals to understand the person, how best to help them and how to manage safely the risks presented.

Staff had completed assessments about other situations where people were potentially at risk. These included risk assessments for mobility, falls, pressure sores, and a safe environment check for their bedroom. These assessments were not always effective because they were unclear. Monthly reviews of risk assessments were not always consistent with details noted elsewhere in people's care records. For instance, in one person's risk assessment for personal care and details on a monthly review showed a different number of staff was needed for support than was stated in their care plan. It was not clear what level of support was required so it there was a risk that this was not consistently planned for or provided.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Three visitors said they thought their relatives were safe in the home, and one said their relative often reassured her that "no-one has hurt them." Staff knew how to recognise abuse and felt people were safe at the service. They said they felt confident that if they raised concerns about people's safety with the manager they would follow them up properly to keep people safe and make sure they were looked into. In a situation where issues of concern were raised with the manager she made prompt referrals to safeguarding authorities so there could be an independent investigation and appropriate action taken.

People were supported by permanent staff who had been safely recruited to their posts in the home. Staff records included the results of checks and references to make sure they were suitable to work with people. These included people's work histories, references, including previous employers, and identity checks. The provider also ensured that checks were carried out by the Disclosure and Barring Service (DBS) to ensure there were no records to prevent them working in the care sector.

Temporary staff were checked by their employing agencies and the provider verified that their procedures were adequate. If issues of serious concern were identified with the work of agency staff the manager made reports to their agency and when necessary to regulatory bodies, such as the Nursing and Midwifery Council and to the Care Quality Commission (CQC).

Requires improvement

Is the service effective?

Our findings

At the last comprehensive inspection in June 2015, we found that the home was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because some people were not supported to have enough to eat and drink. In August 2015 we found people's nutrition and hydration needs were met and they were supported to eat and drink enough to meet their needs. Staff knew people's dietary requirements and talked with other health care professionals when they needed to get further advice and guidance about how to support people safely at mealtimes. At this inspection in November 2015, we found that the provider had continued with these improvements, and people were offered fluids throughout the day and served sufficient amounts to eat.

People were supported to choose where they wanted to have their meals. Some people had lunch in their bedrooms and we saw that staff were attentive to their needs. For example, one person had their food brought to them and a care worker noticed that they were not eating by themselves, so they offered them help and sat with them, which ensured they enjoyed their lunch. A visitor told us their relative enjoyed the meals, saying, "The food is good, the portions are good, and they offer more [food]. They encourage [my relative] to eat."

People did not always benefit from support at mealtimes provided by staff who understood how to meet their needs. We saw a member of staff assisting a person with a meal. The staff member was assisting the person while standing behind and over them. A manager intervened and asked the staff member to sit beside the person, which they did until the manager had left the area. The staff member then sat on a table, slightly behind the person so they could not see each other clearly. The staff member overloaded the person's spoon with food and when they ate only half, they tipped the remainder back into the bowl and mixed it up with the fresh food. We saw that the person looked anxious and unhappy during their meal. The staff member had not told the person what the meal consisted of and did not talk with the person while they helped them. They were disrespectful to the person and did not meet their needs.

We also saw two instances where people did not receive assistance to eat because they were asleep and there was no guidance for staff to follow in these circumstances. We told the manager about this and they said they were arranging reviews of the people's care plans to make sure this did not happen again.

During our observation of lunch, most staff supported people to eat at an appropriate pace and enjoy their meal with dignity. Care workers showed people a tray with both hot options available on plates; they showed them to each person to help them to choose. Staff spoke to people with kindness and addressed them by their first name. Staff gave a person with a hearing impairment extra time to choose what they wanted, and the staff member spoke to them clearly. Care workers showed a good awareness of the individual needs of people during lunch. A care worker noticed when a person had stopped eating and sat with them, offering to cut their food up and sit with them whilst they ate. This had a very positive effect on the person, who enjoyed their lunch talking with the member of staff who maintained the conversation throughout the meal. We saw from looking at this person's care record they were at risk of malnutrition and that staff had followed their assessed needs by gently encouraging them to eat.

People were protected from the risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) for people at risk of malnutrition. People who required monitoring had their weight and body mass index checked at least monthly, and more often if assessments indicated a high risk of malnutrition. Staff had been proactive in obtaining the advice and support of a dietician where a person's weight had dropped unexpectedly. In such cases, a multidisciplinary approach was evident and staff had worked with a dietician and the head chef to create a menu plan that was appropriate for the person's needs. Records showed that such approaches had been successful and that fortified diets were readily available for people to support their dietary needs. There was evidence that the head chef had been involved in a number of dietary planning documents in care plans.

People were supported by staff that did not have regular supervisions to reflect on their working practices. Staff had infrequent formal opportunities to meet with senior staff. Supervision sessions for staff took place twice a year and managers told us the frequency was set by the provider's policy. Appraisal meetings for staff took place each year. Staff said they could talk with senior staff and managers about any concerns they had in between formal sessions.

Requires improvement

Is the service effective?

We saw that managers spent time in the units so they were available informally to staff. The infrequency of formal supervision sessions limited their opportunities for support and to have their training and development needs assessed. This also restricted the manager's ability to ensure their ongoing competence for their roles.

People were placed at risk of not receiving appropriate care to meet their needs. We found inconsistencies in staff completing and recording care tasks. For example, three people who required regular turning to prevent pressure ulcers had records which on the first day we visited did not confirm they had been turned at two hourly intervals. This showed that improvements needed to be made to ensure staff were aware of the care tasks that should be carried out and recorded accurately. Staff completed a chart of a person's food intake but included little detail. For example, although it was recorded that the person ate porridge for breakfast other meals were just described as 'puree'. This did not help to monitor the person's preferences in meals so that the information could be used to provide food that the person enjoyed and ate well.

People and their relatives were confident in the abilities and knowledge of permanent staff who had worked at the home for several months or longer, and were familiar with the people they looked after. People and relatives were less confident that agency staff were knowledgeable about their needs because they did not know people they cared for well. A person who had lived at the home for more than a year told us, this had affected the quality of care they received. They said, "It was fine initially, and then they started to have agency [staff]" and they said the quality of care they received had reduced.

Permanent staff supported agency staff to get to know people's care needs and this impacted on the time they had available to provide care. A staff member told us that on approximately three days a week they had "to spend time telling agency carers what to do and then supervise them."

People did not receive full protection under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) in the way their needs were considered. Although the manager and senior staff knew their responsibilities under the legislation, best interests meetings had not taken place for all of the people who were unable to give consent for care and treatment. The manager told us they planned to hold best interests meetings as part of the process to review care plans. Three mental capacity assessment records showed there were gaps in the process followed. Family members were involved in the assessments but the records did not adequately reflect the support given to people to understand the information provided and communicate their decision back. The manager had made applications for people they believed would benefit from a DoLS order being granted.

Staff worked jointly with healthcare professionals to assist people with their health needs. We received positive feedback from a specialist nurse who advised the staff about tissue viability issues in the home. They told us the home managed tissue viability issues saying, "they are doing so well". Each unit had a member of staff identified as a 'tissue viability champion' who had received specialist training and promoted good practice in this area of care. A person living at the home said they had received good care with a problem they had experienced saying, "[nurse] has done a good job on my leg, clearing up the ulcer."

People benefitted from staff seeking advice from health professionals to inform their care. Staff had promptly contacted multidisciplinary health professionals when a person's medical condition had deteriorated. This had included arranging appointments with a GP, audiologist, social worker and the community mental health team. This had led to a prompt change in the person's care needs assessment, which meant that they had received more appropriate care for their needs.

We recommend that the provider consider advice and guidance from a reputable source about best practise regarding the frequency of formal supervision sessions for staff.

Requires improvement

Is the service caring?

Our findings

We observed some examples of staff engaging with people in a caring and kind manner but this was not always the case. At the inspection in June 2015 we found staff were friendly and polite when speaking with people but they were not always aware of people's communication needs and preferred communication methods.

At this inspection in November 2015 we saw a care worker interact with a person in a way that was inappropriate and uncaring. They helped a person with a meal and raised their voice several times while doing so. Another member of staff saw this and took over assisting the person with their meal. They showed kindness and compassion in their approach to the person. They ensured they were at a level where they maintained eye contact and spoke softly and kindly. The person looked more relaxed when this staff member assisted them and appeared calmer when eating their meal.

People did not always receive care from people who knew their preferences. Each person had a personal profile in their care record that included a page titled 'What people like and dislike about me' to help staff understand them. However, we found that the profiles were not completed consistently and in one care record, the profile was blank.

Generally, people's privacy was protected, however, when we arrived in the home at 7am we saw that many people's bedroom doors were open while they were in bed. We were concerned that this compromised their privacy as we and others passed along the corridor outside the rooms. Personal care took place with doors and curtains closed to protect people's privacy. A person living in the home told us staff always knocked on their door before entering her room and we observed this. .

In most cases people experienced kindness and patience from staff who had time to chat with them if they wanted to. For example, we saw one care worker take a cup of tea to a person in their bedroom. They knocked before they entered, spoke to the person by name and started a conversation by saying, "I love the picture of your cats, what are they called?" This delighted the person, who smiled and showed they enjoyed the interaction. We saw that staff sat and talked with people wherever they were, such as seating areas in the corridors that people liked to use to watch people passing by.

People were treated with regard for their dignity. For example, at a mealtime when a person's apron slipped down, a care worker asked them if they would like help in adjusting it, ensuring that their clothes were protected and their dignity was maintained. A person told us they found the staff were "all very polite".

We saw staff helping people in a thoughtful and caring manner. Two of the domestic staff team took a person out to a shop, they knew the person enjoyed shopping and they had few opportunities to go. The person described the staff as "such lovely [people]." and smiled saying they appreciated their help and kindness. The staff said they were available and knew the person enjoyed going to the shop and they were happy to assist. Their approach was kind and considerate and we could see that the person enjoyed being with them.

People had opportunities to be involved in their care and support and staff recorded their preferences. For example, one record we saw included a list of the toiletries the person preferred to use, including brands of soap, body wash and shampoo. Another person's night-time preferences were noted including that their window and door should be closed, and their bedside light left on overnight. A third person's record stated that they wanted staff to tell them whenever there was a change of staff or a change in the home's daily routine. We saw staff had met this request and this had helped minimise the person's anxiety relating to change.

Requires improvement

Is the service responsive?

Our findings

At the inspection in June 2015 we found people's needs were assessed and plans were in place to support people with them. However, care was not always provided in line with the care plans and advice from specialist healthcare professionals. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in November 2015 improvements had been made and care reflected specialist advice but the involvement of people and relatives in care planning was inconsistent. When people came to live at the home, a senior member of staff prepared a seven-day temporary care plan to help the person settle in and give staff information to meet their needs. Staff then carried out assessments and observations, which they used to write a full care plan. People and their family members were sometimes involved in writing their care plan and staff recorded this on three of the care records we looked at. However, two others did not include people's views despite information that they could have provided them. For example a person's care record stated that they had no problems expressing their needs and wishes but there was no evidence that they had been asked about these or that people important to them had been involved in their care planning. Another person's care record stated they were able to communicate clearly but there was no evidence that they had been asked about their daily needs.

People did not always have their cultural needs recorded or met. In three of the care records we looked at, no cultural needs had been recorded. Although staff told us one person preferred to eat meals that reflected their culture, when we looked on their record of food intake there was no information that culturally appropriate meals had been provided. The manager told us she was arranging care reviews to which people and relatives' views would be sought and taken into account in future care planning.

People did not always have opportunities to choose activities that reflected their interests. Each floor of the home had a notice board displayed that could be used to list the weekly plan for activities in the home. On the third floor we saw that the notice board had only two items listed for the week of our inspection, one of which was 'hairdresser' and the other was 'worship'. This meant that it was not clear to people or their visitors if there were other activities planned. For example a planned afternoon tea party was not recorded on the notice board.

Staff did not consistently record people's preferences regarding activities in their care records. One person's care record stated that their daily activities were, "wandering the corridor" and "lying in bed." We did not find evidence that staff had tried to engage the person in social activities to reduce the risk of social isolation and boredom. This was a concern as the person's social and psychological needs assessment stated that they needed daily stimulation and that they enjoyed flower arranging and gardening. Daily notes did not indicate that they had been offered these activities and two care workers we spoke with could not tell us if they had ever been provided.

When a person was practicing a religion, staff had been able to support them to continue taking part, such as by accompanying them to places of worship or arranging for them to see religious leaders in the home.

We observed that people enjoyed an afternoon tea party, which took place on the third floor of the home during our visit. Volunteers had brought cakes and offered tea, coffee and juice to people as well as the opportunity to talk, socialise and listen to music, and they invited people and their visitors to a lounge Staff encouraged people to go with their visitors and we saw that it was well attended and that people enjoyed it.

The manager had begun to consult with people and their relatives about the care provided at two monthly meetings. There were notices showing details of forthcoming meetings and action points from the most recent meeting displayed in the entrance area of the home. A relative said they had been to a relatives' meeting in September 2015 and 20-30 people had attended. They said the manager had told them about improvements they hoped to make to the home.

People and relatives felt able to raise concerns with the manager and with staff. One relative said, "I let the staff and management know if there are problems and the manager is very thorough."

Requires improvement

Is the service well-led?

Our findings

At the inspection in June 2015 we found there were systems in place to monitor the quality of care provided. However, these were not being used effectively at the time of our inspection, and actions were not taken in a timely manner to address areas identified during audits as requiring improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection in June 2015 we found people were not protected by sufficient management oversight of the home when there was no manager in place. We noted that in the period between the previously registered manager leaving the home in May 2015 and the current one beginning her post in August 2015 fewer audits were undertaken. This was a period of risk to the management of the home but the provider had not provided sufficient oversight. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, at this inspection in November 2015 we found management systems had improved since the current manager began work at the home. The manager had identified areas of weakness in the home and was working towards addressing them. For example they recognised that the home required a permanent and stable staff team, as the high use of agency staff introduced risks to key areas of care such as medicines management and they carried out frequent audits to ensure good practice was maintained. Recruitment to vacant nurse posts was underway during our inspection.

Since the new management team began they carried out visits at night-time and at weekends to ensure that care standards were maintained at all times. They addressed problems they found and had seen changes as a result. For example staff punctuality had improved in response to the greater level of management scrutiny. During our visits we observed managers talking with staff when they saw poor practice and telling them how to improve.

People were supported by staff that did not always act appropriately resulting in a negative unfriendly atmosphere. Staff did not always work effectively together and this detracted from the teamwork that is necessary to provide good quality care. We observed a lack of teamwork amongst the staff at the home. Staff did not always speak to each other with respect or appropriately in front of people and their visitors. For instance, whilst lunch was being prepared in one of the dining rooms, staff just outside began arguing loudly over whose responsibility it was to take food trolleys to other floors. The argument escalated until a care worker in the dining room intervened. We also saw a number of examples of staff speaking to each other unkindly and with unnecessary force, including a member of the catering team speaking to a care worker in an inappropriately aggressive tone in front of people.

The manager had introduced a system of daily meetings for the senior staff on duty, including nursing and senior care staff, the chef, housekeeper, administrative and maintenance staff. These meetings lasted for a short time for the senior staff to discuss immediate issues such as urgent concerns relating to people living at the home and staffing matters. The manager said they found these meetings helpful for ensuring effective communication amongst the senior team about urgent matters.

The manager was registered with the CQC in early January 2016. Another manager was assisting her in the management role until they achieved improvements in the home. There was also a 'clinical lead' nurse placed at the home to provide nursing advice and support to staff. All of the managers were seen working directly with people and accessible to staff during the days we visited. The Operations Director visited the home and supported the managers.

Staff felt the managers were approachable and one said, "I can discuss anything with my manager, she listens, she will look into everything straightaway and take action." Another member of staff commented that the "manager's door is always open" and they felt able to go to them to discuss issues.

The manager notified CQC about events in the home as required by regulation and sent safeguarding alerts to the local authority for investigation. The manager investigated matters of concern and action was taken to prevent recurrence,

Requires improvement

Is the service well-led?

There were plans for effective partnership working to be established. The manager had begun working at the home three months before our visit and was developing relationships with a range of professionals with a view to working together to meet people's needs more effectively.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 ensure that people received care which was person-centred and reflected their preferences** **Regulation 9(1)(b)(c)**

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 ensure that risks were adequately assessed and action was taken to mitigate the risks.** **Regulation 12 (1) (2) (b) (b)**

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 **The registered person did not ensure systems or processes were established to assess, monitor and improve the quality and safety of the service, or to assess, monitor and mitigate the risks relating to the health, safety and welfare or service users.** **Regulation 17 (1) (2) (a) (b)**