

Bondcare (London) Limited

# Ashwood Care Centre

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

The inspection took place on 13 March 2018 and was unannounced.

The last inspection of the service took place on 11 October 2017 when we rated the service Requires Improvement in all key questions and overall. We issued warning notices in respect of breaches of Regulations in relation to person-centred care and good governance, and made requirements in respect of dignity and respect, safe care and treatment, nutrition and hydration and staffing. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all of the key questions to at least 'good'.

At this inspection we found that improvements had been made in all areas however not enough to improve the rating to Good. We found that whilst improvements had been made in relation to the safe care and treatment of people and good governance, further improvements were required in order to meet these Regulations. We found the provider had met breaches of Regulation regarding person-centred care, dignity and respect, nutrition and hydration and staffing. We have rated the service Requires Improvement overall and in the key questions of Safe, Responsive and Well-led. We have rated the key questions of Effective and Caring as Good.

Ashwood Care Centre is a 'care home'. People in care homes receive accommodation with nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to accommodate up to 70 older people. At the time of the inspection there were 46 people living at the service. Accommodation is provided on three floors. People living on the first and second floor were living with the experience of dementia.

Bondcare (London) Limited manage nine care homes within London and are part of Bondcare, a national provider of care homes in the United Kingdom.

There was a manager in post. They had applied to be registered with the Care Quality Commission and this application was being processed at the time of our inspection. 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 and associated Regulations about how the service is run.

People did not always receive their medicines in a safe way and as prescribed.

The provider's systems and processes had not always identified risks such as the way in which medicines were being managed, risks of unsafe support being provided by a visitor and risks associated with infection prevention and control. This meant that they were not able to respond and take action to mitigate these risks.

We found two breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and good governance.

We are taking action against the provider for failing to meet Regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Following our feedback regarding areas of concern, the provider took action to mitigate the risks we had identified.

People's needs were being met, although there was a risk that these would not always be met in a way which reflected their preferences. Information about individual care needs was not always clearly recorded. The staff had recorded when people refused care, but they had not always investigated if there were other ways they could offer care to ensure people had the support they needed in a way they preferred.

The provider had improved the service. They had listened to feedback from the local authority, people using the service, staff and other stakeholders to help identify improvements they wanted. They had also addressed the majority of concerns identified at the last CQC inspection and we could see that there were systems and processes to continue making improvements.

People were happy living at the service. They felt well supported by kind and caring staff. They told us their needs were being met and they were able to make decisions about how they were being cared for. People were treated with dignity and respect and were able to maintain their independence if they wanted this. There were a range of organised social events and activities, and people also received individual support to meet their social and leisure needs.

The staff were happy working at the service. They felt supported by their manager and had the training and information they needed to care for people. There were enough staff to keep people safe and meet their needs. There were effective systems for sharing information amongst the staff team to make sure people received effective care.

People lived in a safe environment. The provider undertook checks on the safety of the environment and equipment. People had the equipment they needed. The home was clean. There had been improvements to design of the environment but further improvements were needed. For example, some bathrooms could not be used and best practice guidance for promoting dementia friendly environments had not always been followed.

People had enough to eat and drink. The staff monitored this and took action when people were identified as at risk. The staff worked with other professionals to ensure people's healthcare needs were being met. The provider had assessed people's needs and preferences and had recorded these in care plans. The staff kept records of the care that they had provided. They had responded to changes in people's needs and had taken action when people fell, became ill or their condition deteriorated. Some people were receiving care and support at the end of their lives. The staff had the skills and support to make sure these people were comfortable, pain free and their preferences were respected.

The provider had acted in accordance the principles of the Mental Capacity Act 2005 and restrictions on people's freedom had been lawfully agreed in their best interests.

There was a clear and visible management team, with the manager supported by the provider's

representatives. People felt they could speak with the manager and that complaints were appropriately responded to. There were systems for identifying and improving the quality of the service and these included asking people living there and others for their views.

## 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** ●

Some aspects of the service were not safe.

People did not always receive their medicines as prescribed and in a safe way.

There were procedures designed to safeguard people from the risk of abuse.

There were enough suitable staff employed to keep people safe and meet their needs.

The provider had systems to learn from incidents and accidents.

### Is the service effective?

**Good** ●

The service was effective.

People's nutritional and hydration needs were being met.

People were cared for by staff who were appropriately trained and supported.

People's needs and choices were assessed so that effective care could be delivered.

The provider acted within the principles of the Mental Capacity Act 2005 and people were asked to consent to their care and treatment.

People had access to external healthcare professionals and were supported with their health needs.

### Is the service caring?

**Good** ●

The service was caring.

People's privacy, dignity and independence were respected and promoted.

People were treated with kindness, respect and compassion.

People were involved in making decisions about their care and support.

### Is the service responsive?

Some aspects of the service were not responsive.

People were being supported in a way which met their needs, although there was a risk that these needs would not always be met.

Care planning information was not consistently clear.

People's care needs were reviewed and the staff responded to changes in these needs.

People knew how to make a complaint.

People who were at the end of their lives were comfortable, pain free and had dignified care.

**Requires Improvement** ●

### Is the service well-led?

Some aspects of the service were not well-led.

The provider's systems and processes did not always identify or mitigate risks.

The provider undertook regular audits so that they could monitor the service.

There had been considerable improvements at the service and there was evidence that these were continuing.

People using the service, their representatives and staff felt that improvements had taken place and that the service was well run.

**Requires Improvement** ●

# Ashwood 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 13 March 2018 and was unannounced.

The inspection team consisted of three inspectors, a member of the CQC medicines team, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection visit we looked at all the information we held about the service. This included the last inspection report and provider's action plan. We looked at notifications we had received from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. The provider completed a Provider Information Return (PIR) on 6 February 2018. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the local authority quality team who were monitoring the service and they shared the report from their most recent visit to the service with us.

During the inspection we spoke with six people who lived at the service and seven visiting friends and relatives. We also spoke with a visiting healthcare professional. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We spoke with the manager, other staff on duty who included nurses, care assistants, senior care assistants, the deputy manager, catering staff, domestic staff and activities staff. We also spoke with two of the provider's senior managers.

The inspection included examination of records. We looked at eight whole care plans and parts of ten other care plans, the recruitment records for six members of staff, staff training and support records, records of complaints, accidents and incidents and audits by the provider. The member of the CQC medicines team inspected how medicines were being managed. We also looked at the environment and equipment being used.

At the end of the visit we gave feedback to the manager and the provider's representatives.



# Is the service safe?

## Our findings

People using the service and their relatives told us they felt safe and that the staff protected them from harm. Some of their comments included, "I feel safe and free from abuse", "[Person] is safe here", "I feel safer here than I did at home because there are staff here at night to look after me" and "The staff keep me safe."

At the inspection of 11 October 2017 we found that there was a risk that people would not receive their medicines as prescribed.

At the inspection of 13 March 2018 we looked at storage, administration, records, policies and systems relating to the management of medicines at the home. The provider had made some improvements since the last inspection, but these were not sufficient and medicines were still not always being managed safely.

The ordering and stock management processes for medicines were not always safe. We found that that the provider had run out of some of two different people's prescribed medicines. This meant these people had not received these medicines as prescribed because they were not in stock at the home. One of the people had been prescribed two medicated creams which were administered by care staff. The record for application of these creams in the person's bedroom stated there was no stock for over one week and the person had not received these medicines during this time. The records stated that senior staff had been informed about this. However, the person's medicines administration records which were completed by senior staff recorded that the person had received these creams each day. This meant the records of medicines being given this person were not an accurate reflection of the medicines actually being given.

Medicines waste was not always disposed of safely. We saw evidence that staff did not always record medicines refused by people on the designated form before disposing of them in the waste medicines bin. We found an unlabelled used bottle of liquid medicine in the medicines cabinet, we inquired about this but the staff were not aware why it was stored in the cabinet. We found a medicine which had expired in August 2017 stored in a bedroom. The medicine had not been prescribed to the current occupant of the room and the person who it had been prescribed to no longer lived at the service. This meant there was a risk that an expired medicine could be used, which has the potential to cause harm.

For some people staff had hand written their MAR charts. We found staff who wrote them did not always sign the MAR charts. Also, a second member of staff had not always checked and signed them. This did not meet the guidance issued by National Institute for Health and Care Excellence for safe management of medicines in care homes. This meant it would be difficult to identify if there was an error made while hand writing the MAR chart.

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

The problems we identified were all on the second floor of the home. Medicines were being safely managed

on the ground and first floors. Following our feedback to the provider they assured us that they would carry out a full medicines audit at the service to identify any further areas of concern. The manager explained that staff involved in administering medicines on the second floor would receive additional training and reassessment of their competencies. In addition, they told us that the deputy manager, who was also the clinical lead at the service, would be based part of each week on the second floor to make sure further problems did not arise.

During our last inspection, we had found guidance was not available for everyone who had been prescribed medicines on a when required basis to help manage their pain. At this inspection, we saw evidence that guidance was available for staff to identify symptoms of pain to help give people their medicines consistently.

Some people were prescribed high-risk medicines to manage their long-term health conditions. There was guidance in people's care plans for staff to identify likely side effects of these medicines and information on how to manage them.

There was a medicines policy in place at the home. We saw evidence of medicines audits had been carried out by the provider shortly before the inspection. A pharmacist from the local Clinical Commissioning Group was supporting the home to improve systems relating to medicines management and help review people's medicines.

The staff members checked and recorded temperatures daily of areas where medicines were stored, these were within the required range.

We observed people receiving their medicines in an appropriate way.

The provider had recently changed to a new supplying pharmacist. The agreement with the pharmacy included regular audits of medicines. The staff responsible for administering medicines had received training and had signed up for additional training with the pharmacist.

At the inspection of 11 October 2017 we found people were placed at risk of harm because there was not enough equipment to meet their needs.

At the inspection of 13 March 2018 we found that improvements had been made. The provider had purchased slings for all the people who needed these when they were assisted with moving. The slings were labelled and stored in people's bedrooms. There were schedules to make sure these were regularly cleaned. There were enough hoists so that people could be supported to move without having to wait for equipment. Some people had pressure relieving mattresses and cushions. Everyone who needed one of these had been provided with one. The staff made regular checks to ensure that the pressure was right for the person using these. The staff were aware of how to use equipment and check it was safe to use, for example how to determine the right pressure level for mattresses. People who required beds which could be adjusted to different heights had these. There were also bedrails for people who had been assessed as requiring these, mats to cushion people who may roll out of bed and sensors to alert staff that people who were at risk of falling were moving in their rooms. There was evidence of regular checks and services for all equipment. Where faults were identified action had been taken to remedy these.

The majority of people who required wheelchairs or walking aids had these. However, one visitor told us they were waiting for their relative to receive a walking frame after they had been assessed. The manager told us that they were liaising with the relevant professionals about this.

Sharps bins are sealed containers used for the disposal of needles, lancets and other sharp medical waste. We found that sharp bins at the service were overflowing posing a risk of injury for the staff who used these. We advised the manager of this and they agreed to arrange for the bins to be collected and exchanged for new ones. People using the service were not at risk because they could not access the rooms these were stored in.

People using the service told us that the home was kept clean. We observed it to be clean throughout the inspection visit. Cleaning staff could be seen working on all floors. All staff wore protective equipment such as gloves and aprons, and they disposed of these appropriately. The provider carried out infection control audits to make sure the environment was clean. The manager kept a record of all infections and action taken to care for people and to prevent the spread of infection to others.

The provider had procedures designed to safeguard people from abuse. The staff had received training about this. They were able to describe different types of abuse and what they would do if they were concerned about someone's safety. There were posters on display around the home giving information about how to recognise and report abuse. The provider had taken appropriate action when there had been allegations of abuse and when people were considered at risk. They had worked with the local safeguarding authority and other agencies to investigate these allegations and to protect people from further harm.

The risks to people's safety and wellbeing had been assessed and planned for. Individual assessments included risks associated with assisted moving, falling, use of equipment, skin integrity and nutrition as well as people's physical and mental health. The assessments included ratings to guide staff as to how severe the risk was and there were action points which were individual to each person's needs. The assessments were reviewed each month and following a fall or change in someone's condition. Information about risks relating to the way people should be cared for was available in people's snap shot care plans which were placed in their bedrooms.

The provider had allocated two members of staff to be falls champions. Their role included updating themselves on best practice, working with the local authority and supporting other staff to reduce the occurrence of falls within the service. The staff responded appropriately to accidents and falls. During our inspection we witnessed one person falling. The staff immediately attended the person and made sure they were safe and comfortable. They checked for injury and helped the person to return to a standing position. The staff then alerted the person's GP to the fall and monitored their vital signs and wellbeing.

We saw that the staff recorded all accidents, incidents and falls. The manager viewed these records to make sure the staff had responded appropriately. They looked for any trends and patterns such as the same time of day, location or member of staff. We saw that they had good systems for this. There was evidence that they learnt from incidents and shared information with the staff team and others so that they could reduce the likelihood of these reoccurring. For example, the manager held supervision sessions with the staff team to discuss accidents and the response to these.

People told us that they had call bells in their rooms to request staff assistance. They told us that these were usually within reach and that staff came quickly when the alarm was activated. We observed that the staff responded quickly when call bells were activated.

The provider took steps to maintain a safe environment. The home was free from trip and other hazards during our inspection. The staff undertook regular checks on health and safety. There was a dedicated maintenance team who attended to any repairs which were needed. Information about emergency evacuation and fire safety was on display and the staff knew where each person's individual evacuation

plans was held. The provider organised for checks by external agencies on electrical safety, water supply and temperatures, gas safety and fire safety. A fire risk assessment had been carried out shortly before our inspection, although the provider was waiting for a written report of this.

The majority of people and visitors we spoke with told us they felt there was enough staff with one person commenting, "It feels like they have increased the staffing to me" and another person telling us, "I can see more staff around than there was before." Some visitors and staff told us they did not think there was enough staff on the second floor. The manager told us that they were in the process of recruiting additional staff (including nursing assistants and senior staff), some staff were waiting to start and some were completing their inductions. They told us that the deputy manager would also be supporting staff on that floor during busy times.

The provider undertook checks on the suitability of staff they employed. These included a full employment history, references from previous employers, checks on their identity and eligibility to work in the United Kingdom and checks with the Disclosure and Barring Service to identify if they had any criminal records.

## Is the service effective?

### Our findings

At the inspection of 11 October 2017 we found that the provider was not always meeting people's hydration needs. They had failed to respond when one person was not drinking enough and people did not always have access to drinks.

At the inspection of 13 March 2018 we found improvements had been made. The staff were monitoring people who had been assessed as at risk because of low fluid intake. Target fluid amounts had been recorded and these reflected guidance from visiting healthcare professionals. The staff recorded the amount of food and fluid people consumed. These records were monitored by the nurses and there was evidence that they had sought professional guidance when people were not drinking enough.

Throughout the inspection we saw that drinks were available for people. There were jugs of cold drinks available in bedrooms and these had been labelled with the date and time so we could see they were fresh. People had drinks within easy reach and we saw that people were offered a choice of hot and cold drinks throughout the day.

People using the service told us they liked the food and that they had choices about what to eat. They told us they had enough to drink.

People's nutritional needs had been assessed using an approved tool to identify any risks relating to this. There was evidence of care plans which reflected these assessments. People were regularly weighed and changes in weight were recorded, reported to the manager and responded to. There was evidence of work with external professionals to develop individual dietary plans. There was information for care staff and the kitchen staff regarding people who required supplements or special diets.

The catering staff had detailed information about people's individual needs and preferences. They catered for specialist diets and were able to describe different people's specific needs. Their menu offered a number of different alternatives for each meal. The chef told us they spoke with people about their preferences and whether they had enjoyed meals. Menus were reviewed and updated to reflect seasonal changes. All meals were freshly prepared at the service. The menu was nutritionally balanced and varied.

At the inspection of 11 October 2017 we found that the staff who cared for people did not always get the support they needed. People were not always cared for by suitably qualified and experienced staff. For example, we found that nurses were not always supported to keep their clinical knowledge up to date and care workers did not always have a good knowledge of how to care for people living with the experience of dementia. Some staff had also commented that on line training was not always effective.

At the inspection of 13 March 2018 we found that improvements had been made. The provider had employed a new deputy manager and clinical lead. They were taking a lead role in supporting the nurses to further their knowledge and skills. The nurses told us they were being supported to access a range of training and to gain the skills they needed for revalidation of their registration with the Nursing and

Midwifery Council (NMC). There were regular meetings for the nurses to discuss clinical issues. They explained that they now felt supported and could ask for additional training and information when they needed this.

The provider had enrolled all staff on training to ensure they had best practice knowledge regarding dementia. There was information about dementia and supporting people provided to staff and displayed around the home. The staff supporting people on the day of our inspection demonstrated that they understood about people's needs in this area.

The provider had their own training team who arranged for face to face training opportunities for the staff. The staff had also completed on line training courses. New staff undertook training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The provider had systems to ensure that staff undertook regular training updates. The staff confirmed that they were expected to keep their training up to date. In order to ensure the staff had understood on line training and that this had been effective, the manager had regular group and individual meetings with staff to discuss key topics and check their learning and knowledge.

People using the service and their relatives told us that they thought the staff were trained and skilled. Some of their comments included, "I feel the staff have the skills needed to care for [person], they have a good approach and do their job", "They seem well trained" and "It is a difficult job and they do it well."

There were systems for the staff to communicate with each other and share information to deliver effective care and support. There were regular team and individual meetings and daily handovers of information about the service. The provider's representatives regularly visited the service and the manager had opportunities to meet with other managers for shared learning and to discuss good practice.

At the inspection of 11 October 2017 we found that some aspects of the environment were not suitable to meet the needs of people living with the experience of dementia. We made a recommendation in respect of this.

At the inspection of 13 March 2018 we found that improvements had been made to the environment and some areas had been decorated. The provider's representatives told us that they were still in the process of improving the environment and providing better signage and other features in line with best practice recommendations for dementia friendly environments.

The relatives of people told us that they had been asked for their contribution when the manager was assessing people's needs. People also commented that they had been made welcome when they moved into the home. One person explained, "The way I was received and the manner of care given to me were very good."

The provider undertook assessments of people's needs and preferences before they moved to the service. The assessments included a range of good practice tools to assess people's health and care needs. The assessments had been incorporated into care plans.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.

The staff had completed capacity assessments in respect of different decisions about people's care. These were recorded. Where people lacked capacity the provider had made decisions with others in people's best interests. There was information about legal representatives for people. The provider had made applications for DoLS as needed and kept a record of the authorisations so that they could reapply when needed and to make sure any conditions were incorporated into care plans.

People were supported with their healthcare needs and had access to external professionals when they needed. The provider employed nurses who monitored people's health and liaised with other professionals. We saw care plans for specific healthcare conditions and meeting people's needs. There was evidence of consultation with other healthcare professionals and that their advice was sought and followed. The GP regularly visited the service. The staff kept a record of information they wanted to share with the GP during these visits. We saw records of incidents and when people had become unwell. These showed that the staff had responded appropriately and had called for an ambulance when needed. When people had developed a wound the staff had created a care plan specifically for this which included photographs so they could track the progress of the wound.

# Is the service caring?

## Our findings

At the inspection of 11 October 2017 we found the staff were not always kind and did not consider people's feelings. In addition, they tended to focus on the tasks they were performing rather than the person they were caring for.

At the inspection of 13 March 2018 we found that improvements had been made.

People using the service and their relatives told us that the staff were kind, caring and considerate. Some of their comments included, "From my point of view they treat me very well", "They seem very respectful and kind to me", "All the carers know [person] well and understand [their] needs", "The carers give me the dignity and respect I deserve" and "They respect me during my care."

There were a small number of incidents we observed where staff did not always communicate clearly with people. For example, we saw that during lunch in the dining rooms of the ground and second floor the staff did not offer people choices or speak with people apart from when they were performing a task. However, these incidents were isolated and we saw that the staff were polite and responded to people when spoken to. The lunch time service in both areas was a busy time of the day. We discussed this with the manager who agreed that some staff still needed support to remember to focus on individuals rather than the tasks they were performing when they were busy. They explained they were continuously working with the staff to establish better practice and we saw evidence that dignity and respect had been part of a recent group learning session.

Apart from the above, we saw that most staff communicated clearly with people throughout the day offering them choices and showing kindness and respect. For example, during lunch on the first floor people were offered a choice of drinks and shown two different plated meals so that they could make a decision about what they ate based on what the food looked like.

The staff demonstrated a good knowledge of different people and the way they wished to be treated. For example, we heard staff being sensitive and calm when people needed reassurance and sharing jokes with people they knew would appreciate some humour. Throughout our inspection we saw that one person regularly became unsettled and scared. We witnessed a number of different staff reassuring this person and offering them comfort. At one point the person became distressed when a staff member moved away from them. The staff member showed kindness and compassion in response and stayed with the person until they felt more settled. In another example, we saw a person needed to move to a different room and was unsteady on their feet. A staff member allowed the person to be independent but stayed with them reassuring them and speaking with them all the time whilst they moved to a different part of the building.

We observed the domestic staff being kind, supportive and caring in their interactions. One person complimented a member of the housekeeping staff saying how they always helped them when they needed. We saw this, with the domestic staff being attentive when someone called out for help and explaining what they were doing when entering people's bedrooms.



The provider had assigned one member of staff as a dignity champion whose role included promoting dignity issues around the service. The manager had created a display in one corridor designed to support people, visitors and staff to think about the importance of dignity and respect..

We asked if people had opportunities to spend time with others if they felt lonely. They told us that they did. Some people commented that their families visited regularly. Others told us that they were able to spend time with people in lounges if they wanted to.

People's privacy was respected. Everyone we spoke with told us that they had been asked if they had a preference for male or female care workers supporting them to get washed and dressed. They told us that care was provided behind closed doors and we witnessed this, with staff taking care to ensure curtains were drawn and doors closed before they offered support. The staff used people's preferred names and these were recorded in their care plans. We saw that the staff knocked on bedroom doors before entering.

People using the service and their relatives told us that they were involved in making decisions about their care. Some of their comments included, "My family make the decisions which relate to my care and support", "I feel I am involved in all the decisions regarding my care", "Myself and my family are able to make decisions" and "The staff ask me about what I want and I am able to make decisions, for example where I spend my time and what I am going to wear and eat." People's preferences were recorded in their care plans. We saw the staff offering people the opportunity to make decisions. For example, some people chose to remain in their bedrooms and others chose to spend time in communal areas. People were not rushed and were able to get up and go to bed when they wanted.

People told us they were supported to maintain independence where they were able. One visitor explained that their relative could still stand and walk around with some support and that the staff encouraged this. Some of the other comments we received included, "I like to keep to myself in my own room and the staff let me do this", "I can do things for myself but assistance is always there if I need it", "The staff encourage [person] to eat and drink independently and to do things for [themselves]", "[Person] has always liked to be independent and I am pleased that the staff respect this and help [them] to feel they are still a bit independent" and "They help me to keep going and doing things for myself, this makes me happy."

## Is the service responsive?

### Our findings

At the inspection of 11 October 2017 we found people's needs were not always recorded and planned for and they were not always supported in a way which met their needs and reflected their preferences.

At the inspection of 13 March 2018 we found that improvements had been made. People using the service and their relatives told us that they felt their needs were being met. They said that the staff offered them the help and support they needed. One relative explained that when something had gone wrong they had been able to speak with the manager and this had been put right. People said that care was provided when they needed it.

We saw that records indicated people received support with washing, dressing and personal care. People were offered regular showers. We saw that people were clean and well presented in clean clothes. However, a large number of records we viewed indicated that people regularly, and in some cases always, refused oral care (for example being supported to brush their teeth). We discussed this with the manager. They agreed to review why this was being recorded and to audit how people were being supported to maintain good dental hygiene if they were refusing care. The day after the inspection visit the manager told us they had distributed information giving advice to staff on how they should support people who consistently refused to have their teeth cleaned. The manager told us they would monitor this area of care to make sure people were receiving the support they needed in a dignified and appropriate way.

One person whose care plan we viewed included information that they had been diagnosed with epilepsy, a condition which can cause seizures. We asked the staff how they would respond if someone had a seizure. Some of the staff responses indicated that they did not have a confident knowledge of this area. We discussed this with the manager. The day after our visit the manager told us they had arranged for all the staff to receive specialist training regarding epilepsy.

Whilst people confirmed that staff met their current care needs, we asked them if they also talked with them about their lives and things which were important to the person. Some of their comments included, "I know the staff have had training in this and they did ask us once", "They talk to me about what they are or might be doing for [person] rather than about [their] life", "Sometimes I speak with some of the staff and we can have a good conversation about my past life" and "Some of the staff do." The provider had started to work with people and their families to make sure there was a record about people's lives before they moved to the home and things that were important to them. We saw that some information was available but that this did not always give a good amount of detail. This was also identified by the local authority during their monitoring visit. The manager told us this was an area where they were continuing to develop so that the staff had a better understanding of the person and not just about their current needs.

People's care needs were recorded. However, care files contained out of date information as well as current information and it was not always easy to access the most up to date care plan for each person. This was due to the staff using a combination of templates from the previous provider and new records. We found it difficult to locate care plans about specific needs for two individuals, although the manager showed us

where this information could be located and we saw that it was available. The staff told us that they did not regularly use the care plans to access information and that they shared information verbally and using other records. We spoke with the staff about individual people and their needs. All the staff we spoke with had a good knowledge about people they were caring for. They knew about their individual needs and preferences.

The manager told us that they were in the process of updating all care plans to the provider's new templates. We looked at one care file where all information was recorded in the new format. This was clear and appropriately detailed. It was easy to track how the person should be cared for. In addition, there were new documents being used to record the care being given for each person. The templates for these were well designed booklets which explained the expected outcome and gave instructions for the staff to complete. The booklets were kept in people's rooms and included a snapshot care plan of people's needs. The staff had recorded when they had provided care and support to people. There was room within these booklets for families to record information about their visits, which helped to ensure anything they wanted included within records was being shared and understood by the staff. We saw that the staff had used these records effectively and we could see that care was being provided as planned. There was evidence that the staff had responded to changes in need, for example recording when people's mobility, health, appetite, condition of their skin or communication had deteriorated this had been shared with the senior staff and nurses who had reviewed the person's needs and taken appropriate action.

The provider had a system of "resident of the day" whereby they reviewed people's care once a month. The review included input from all departments at the service and a holistic review of their care and support, for example including checking their bedrooms, meeting with the chef, reviewing their social activity interests as well as looking at different care and health needs. There was evidence this review system was working well and enabled the staff to identify changes in people's needs or particular concerns. However, the provider did not let people or their families know in advance when the reviews were taking place. We discussed this with the manager who agreed that they would give advanced warning to the person and their family in the future so they could actively take part in the review.

People told us that their friends and family were always made welcome by the staff and the visitors we spoke with confirmed this. One visitor told us, "The hospitality is great and we can help ourselves to tea and coffee." They explained that the staff contacted them if there were any changes for their relatives and they felt confident they were being adequately involved in planning their relative's care.

The provider employed three activities coordinators to work at the service. People told us that they were aware of organised activities and had been asked to join in with some of these. Social activities were advertised on notice boards around the home. There was a wide range of different organised events including games, craft activities, baking and social gatherings.

We spoke with one of the activities coordinators who explained how they ran group sessions and offered individual support to people who did not want to join in the group activities. They kept records of this and we could see that people were supported with their particular interests. The activities coordinators kept a file showing photographs of events and activities which they explained they showed to families and people using the service. They told us that they catered for individual needs and went on to describe some of this support. This included, encouraging one person who wanted a job to support others with limited sight or dexterity to fill in bingo cards and allowing another person to help tidy up after activities, because they wanted to do this.

Social activities were held throughout the home and we saw people being supported in different ways

throughout out visit. There was a dedicated room which the provider was converting into a tea room which people could use with their families.

People using the service and their relatives told us that they knew how to make a complaint. There were posters containing the complaints procedure situated in bedrooms and communal notice boards. The manager kept a record of all complaints and the action taken to investigate these and resolve any issues. The provider's quality assurance systems identified any common themes to complaints so that they could act on these. There was evidence of learning from complaints and concerns through staff discussions, meetings and changes to practice.

Some people were being cared for at the end of their lives. We saw that care plans which outlined their needs and preferences were in place. The staff had received training about caring for people at this time. They worked closely with external palliative care teams to make sure people were receiving the care and treatment they needed. There was evidence of close working relationships with the external professionals to monitor people's pain and changes in their condition. People's wishes regarding resuscitation had been recorded. Where people lacked capacity to make a decision about this, we saw evidence that their representatives, staff and other professionals had made decisions in their best interests, and these were recorded. The provider had received thank you cards from relatives of people who had passed away at the service. One of these read, "[Person] had a peaceful end and we cannot thank you enough."

## Is the service well-led?

### Our findings

People told us that they were happy living at the service and with the care provided. Relatives also spoke positively about the care provided to their loved ones. Some of the comments we received included, "I am very happy with the care and support received", "They try their best", "[Person] is well looked after", "The staff are very good to [person]" and "I am very happy here and happy with the staff here."

People using the service and their relatives told us that there was a respectful culture at the service where people were encouraged to respect and support each other's backgrounds and identity. One visitor commented, "I feel things are different now and the manager has created a more inclusive atmosphere."

The staff told us they felt improvements had taken place at the service. They spoke positively about the manager and provider's representatives, telling us that they felt supported.

At the inspection of 11 October 2017 we found that the provider's systems for monitoring and identifying risks were not always effective. We also found that records were not always accurately maintained.

At our inspection of 13 March 2017 we found improvements had been made. However, the provider had not identified that people were being placed at risk from the unsafe management of medicines. For example, we found that staff had not always ensured medicines were available for people, had inaccurately recorded the administration of some medicines and had not disposed of all medicines appropriately. The provider had undertaken their own audits of medicines management but these risks had not been identified.

We also found that action had not been taken to mitigate other risks. For example, during the inspection we witnessed a visitor taking a walking frame belonging to one person and giving this to another person to use. A member of staff was present and did not intervene, even though the person using the frame had not been assessed to make sure they could use this type of frame safely.

We found sharps bin used to store sharp clinical waste were overflowing posing a risk to the staff using these.

We found that the provider had failed to identify that a large number of people had regularly refused oral care. Therefore they were unable to investigate why this had happened or take appropriate action to ensure people had the right support.

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

The provider's response to our findings showed that they took immediate steps to mitigate these risks. They put in place systems which would minimise the risk of further problems in these areas.

Some care plans included information which was out of date alongside current information meaning it was difficult to access the most recent care information. However, records of care provided had been accurately completed and showed how people had been cared for and supported.

The registered manager for the service was one of the provider's regional support managers. They regularly visited the service and supported the manager. The manager had been in post since October 2017 and had applied to be registered with the Care Quality Commission. This application was being processed at the time of the inspection. The regional support manager told us they would cancel their own registration as manager once this process was complete.

People using the service and their relatives told us that they liked the manager and had opportunities to speak with them. Their comments included, "She seems very nice and caring", "The new manager is good and has made great improvements", "I like the new manager very much", "She seems very good and nice" and "The new manager has made improvements to this place."

The manager had a qualification in leadership and management, alongside vocational qualifications in dementia, end of life care and business administration. They had experience of working in and managing other care homes before they started work at the service. The provider had recruited a deputy manager who had started work shortly before our inspection. They were a registered nurse and the clinical lead for the service.

The manager and other heads of departments at the service met each day to discuss the service. Their meetings included an overview of any concerns, incidents and action needed to make improvements. In addition, the nursing and care staff had a hand over of information about people's specific needs.

The provider had systems for monitoring the service and improving quality. Since the last inspection they had taken action to make improvements in all areas and had met four of the six breaches of Regulation. There were regular audits of all aspects of the service including, wounds, infections, accidents and incidents, complaints, care planning, catering, finances, medicines and safeguarding alerts. The audits were comprehensive and we could see that where concerns were identified these had been recorded and acted on. We could see that staff were informed when improvements were needed. There was evidence of increased monitoring of the staff, of additional training and information for staff and better support so that they could express concerns they had.

People using the service and their relatives were invited to take part in meetings about the service. The provider told us that they would also be sending out satisfaction surveys to gain feedback from people using the service and other stakeholders.

The local authority quality monitoring team undertook regular visits to the service. The professional who carried out these reviews told us they had seen improvements at the service. They shared the latest report of their findings with us. Their most recent visit had taken place on 14 February 2018. They had recorded that improvements had been made and further improvements were planned.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>The registered person did not always operate effective systems and processes to ensure that they assessed, monitored and mitigated risks relating to the health, safety and welfare of service users and others.</p> <p>Regulation 17(1) and (2)(b)</p>