SCL Care Limited

Redbrick Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 22, 23 and 25 January 2018 and was unannounced.

Redbrick Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 37 people in one adapted building and specialises in providing care to older people some of whom are living with dementia, and or physical or sensory disabilities. In addition the service provides Pathway 3 beds. [These are for people who had been discharged from hospital for short term care].

The service did not have a registered manager in place. There had been three changes of manager since the home began operating in September 2017. At the time of our inspection Redbrick Court had a new manager who had been managing the home for a few weeks. The provider had submitted an application to register this manager for Redbrick Court. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This is the first inspection since the provider registered with the Care Quality Commission in July 2017. This inspection was brought forward because we received some concerns and complaints about the service and we wanted to make sure people were receiving safe care. The concerns related to management changes, medicines training for staff and infection control practices. During this inspection we found no evidence of people being harmed by poor practice and saw the provider was taking action to improve the management of the home and the delivery of care to people.

Our findings showed that staff knew how to recognise signs of abuse or harm and how to report this. Staff knew the risks people faced in relation to their health conditions and how to support people with these. However the monitoring of risks needed to improve to ensure that people were being supported consistently, safely and in line with their assessed needs. There had been occasions when staffing levels had not been sufficient to meet people's needs. Recent improvements in staffing levels were evident and showed staff responded promptly to people. The provider had taken action to ensure people received their medicines from staff who had been trained to administer these safely. There were processes in place to ensure the premises and equipment were regularly checked and to manage the prevention and control of infection. The manager reviewed accidents and falls to ensure people had the right support to keep them safe.

Staff had not had effective support or supervision and we found some gaps in training due to the training schedule being interrupted by the changes in management and staff turnover. Plans were in place to

address this shortfall and staff were confident in the support they currently had from the new manager. People had no concerns about staff skills to support them. Staff sought people's consent before providing personal care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However further development of these processes was needed to ensure related assessments of people's capacity were undertaken.

People told us that the meals had improved recently and it was evident that people were offered a choice of meal. The cook was working in the home temporarily whist the post was recruited to but had information about people's likes and dislikes. People received regular drinks throughout the day, but the monitoring of people at risk of dehydration had not been consistent. There were effective processes in place to ensure staff communicated effectively between themselves and with other organisations. People were supported to live healthier lives and have access to other professionals to meet their needs. The premises were suitable to meet the needs of the people who used the service.

People were complimentary about the caring approach of staff. There were positive comments from relatives about the compassion staff showed when caring for people and how they had protected people's dignity. People were supported to regain their independence following an illness and people enjoyed undertaking daily tasks in line with their independence. People were supported on a daily basis to express their views about the care they received, although resident meetings had not been fully established.

We saw staff responded without delay when people required support and people described staff as responsive to them. People were supported with some activities and events, but this was reliant on care staff availability. The provider had invested in facilities that were designed around people's specific needs, such as a cinema room, sensory room, garden room and library but these had not been fully utilised. Plans to structure activities and staffing levels to accommodate people's needs in this area were evident. People and relatives we spoke with knew who they could speak with to raise any concerns and action to address any concerns had been taken. The provider had linked with other organisations to source training for the staff team in relation to providing people with compassionate end of life care when this was needed.

There had been inconsistent management of the service due to a turnover of managers. The leadership of the home had recently improved although a full management team was not in place to ensure staff performance and to maintain a good standard of care delivery to people. The provider was overseeing the service and supporting the manager to check that tasks were being carried out effectively. Quality assurance systems were in in place but needed strengthening to ensure any risks to people were identified and mitigated. The provider had established links with other agencies to gain advice and share best practices to improve the quality of care to people. People's views on the service were sought and staff were confident in the new manager to drive improvements.

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.

Potential risks to people's health were assessed but not consistently monitored or actioned to reduce risks. There had been occasions where people had not been supported by enough staff to provide their care. People felt safe living at the home and staff understood how to recognise abuse and how to report it. People received medicines from trained staff so that medicines were administered safely. The premises and equipment were regularly checked so they remained safe and systems were in place to manage the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not had effective support, supervision and training. People's consent was sought but their capacity was not always assessed to ensure staff worked in line with the principles of MCA and DoLs. The monitoring of risks related to people's nutrition was not consistent. People's needs were assessed and plans provided sufficient information about people's needs to ensure these could be met effectively. Staff communicated effectively between themselves and with other organisations. People were supported to live healthier lives and have access to other professionals to meet their needs. People were encouraged to personalise and adapt their own rooms to their individual likes and needs.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring to them. Staff respected people's privacy and dignity and encouraged people to regain and maintain their independence. People said staff sought their views and they were able to express their views about the care they received.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning of their care. People accessed a variety of activities and further facilities had been created to enhance this. People were encouraged to speak out and raise any concerns or complaints and could be confident these would be listened to. There were processes in place to ensure people would receive appropriate care at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There had been many challenges to the service with inconsistent management and a turnover of staff which had affected the provider's plans for delivering quality care. The management structure was not fully established and staff had not had consistent support to guide good practice. The provider's audits needed strengthening to ensure risks to people were monitored effectively. The provider had established links with other agencies to gain advice and share best practices to improve the quality of care to people. People's views on the service were sought. People and staff spoke positively about the new manager.

Redbrick Court

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 visit took place on 22, 23 and 25 January 2018 and was unannounced. The inspection team consisted of two inspectors, one of whom was observing the inspection being carried out.

We received some information from a whistle blower sharing concerns about the service related to management changes, medicines training and infection control practices. A whistle blower is a person who reports any unsafe or abusive practice at a home. As a result of these concerns we brought our inspection forward and used this information to plan what areas we were going to focus on during our inspection.

We looked at the information we already held about the provider. This included information from the provider in response to these concerns and the management changes in the home as well as notifications they had sent us. Notifications contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also reviewed information about the care home from the local authority who commission services.

During our inspection visit we spoke with nine people who used the service and three people's relatives. We spoke with the manager, the Operations Director, four staff members and the cook. We spoke with a visiting health professional who was supporting people within the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We sampled four people's care plans and medicine records. We sampled records used by the provider to manage the service such as accident records, falls log, complaints, surveys, two staff files, induction processes, staff rotas, menus, audits conducted by the provider which included infection control practices, maintenance of equipment, staff and residents meeting minutes, handover information and daily records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe. One person we spoke with said, "I do feel safe and everyone treats me well". Another person said, "I was a little worried when I first came because it's all new, but I've never seen anything that would worry me". A relative told us, "I'm confident that [person] is safe here; I worried at first but if something was wrong [person] would say and from what I've seen the staff are very nice". One person described an incident that made them unhappy and told us that they had spoken with staff and that steps had been taken to address this. The person said, "I'm not worried now it's been sorted".

Prior to our inspection we had information that the senior staff on nights had not been trained to administer medicines. We found all staff who administered medicines had completed safe medicine training and a competency assessment had been carried out to ensure their practice was safe. People and relatives we spoke with did not have any concerns about how their medication was managed. One person told us, "I came from hospital and have a lot of new medication but they [staff] sort it out and I get it at the right time". We observed staff followed safe practice by checking people's medicines prior to administering it. Staff explained to people what their medicine was for and enquired if people needed pain relief. Protocols were in place to guide staff when to give 'as required' medication. We noted that several medicines were administered directly from the original containers for those people who had arrived through the Pathway 3 beds. [These are for people who had been discharged from hospital for short term care]. The checking process took considerable time as these people's medicines had not transferred over to the pharmacy system. These medicines had not been included in the checks to ensure staff were administering these correctly. The manager told us they would include a sample in their next audits.

Prior to our inspection we received information that the provider did not have procedures in place for infection control; specifically for the disposal of clinical waste such as incontinence pads. We saw that the provider had a clinical waste contract for the collection of waste and that staff used the correct containers to store waste. We observed staff regularly using gloves and aprons when supporting people with personal care and or assisting with non-care tasks such as meals or medicine administration. Domestic staff were employed and we saw that all parts of the environment were clean, bright and odour free. The property was well maintained and flooring intact to prevent surfaces from harbouring harmful bacteria. The training records showed staff received infection control and prevention training . Toilets and bathrooms contained suitable hand washing facilities and guidance on how to prevent the spread of infection. Hand gel was freely available around the home and we saw staff using protective personal equipment (PPE) effectively. The provider conducted regular audits to ensure staff maintained good hygiene standards.

Staff we spoke with were familiar with people's individual care needs and any related risks, such as poor mobility and a risk of falls. A member of staff we spoke with told us, "Risk assessments are carried out as soon as someone is admitted; the person and their family are involved and then we would follow the plan and monitor them". However, we found that although staff were aware of people's risks, the monitoring of risk had not always been consistent. For example, we saw a person at risk of developing pressure sores had not been supported to change their position at the recommended two hourly intervals. A second person's records showed they were not always being checked during the night at the intervals identified. We

discussed these shortfalls with the manager and provider's representative. They acknowledged that systems were needed to ensure that people were being supported safely and told us this would be addressed immediately via delegating senior staff to check at the end of each shift.

The provider had systems in place to ensure that all accidents and incidents were recorded and acted upon. We saw that measures were in place to reduce the risk of reoccurrence and to ensure that people remained safe. For example people were referred to healthcare professionals or the correct equipment was sourced to support them. Care plans and risk assessments were updated as a result of changes to people's needs. However accident records showed there had been a number of falls in the previous month. Our analysis of accident records showed there was a pattern with the majority of falls occurring between 7pm and 12pm. A monthly report of falls was in place but did not identify patterns which could assist the manager to look at other factors such as staffing levels as a means of reducing falls. The manager advised that she would implement this.

There was mixed feedback from people about the staffing levels. One person told us, "I think it's alright; there seems to be staff when you need them". Another person said, "I'm not sure, sometimes I think they have been a bit short". A relative told us, "I think the staffing levels have got better but maybe they could do with some more". Staff told us that on occasion staffing levels had fallen due to unreliable staff who no longer worked at the home. The home was not at full occupancy and we saw there were sufficient numbers of staff to keep people safe from harm. We did not see any delays in responding to people; buzzers were answered promptly and staff spent time chatting with people. There had been a turnover of staff as well as managers within the home and this had impacted on staffing levels and consistency of care. In an attempt to manage this the provider was recruiting new staff to fill vacancies and in the interim staff from the provider's other home were working regular shifts within Redbrick Court. The manager showed us a dependency tool used to assess people's needs and calculate staffing levels. We also saw she had revised the admissions criteria so that people with higher dependency needs were not admitted until such time as a core group of staff were in place. Staff had received training on keeping people safe from abuse and knew how to raise concerns both within the organisation and with external agencies. Staff told us they were confident the manager would take action if they raised concerns. There had been no safeguarding concerns raised about this service at the time of the inspection. The manager informed us that any safeguarding matters would be reviewed to establish if any lessons should be learned. The provider told us that any such incidents would be shared with them in a weekly report prepared for them by the manager so that they could oversee any necessary actions.

The provider had systems in place to ensure staff managed any emergencies, for example people had personal emergency evacuation plans in place detailing the equipment and support they required to leave the home safely in the event of a fire or any other emergency. The provider had systems in place to ensure the premises and equipment was regularly checked. This ensured fire detection systems and equipment, as well as gas safety, lifts and equipment such as hoists and nurse call systems were inspected for safety as well as visual checks on window restrictors and door security.

The provider had followed safe recruitment procedures when employing new staff to ensure that people were not placed at risk through their recruitment practices. Staff confirmed that reference checks with their previous employers had been sought and a Disclosure and Barring Service (DBS) check carried out before they commenced employment and records we saw confirmed this. The DBS helps to prevent unsuitable people from working with people who used the service.

Requires Improvement

Is the service effective?

Our findings

Our discussions with staff identified that their training and supervision had been interrupted. Changes in the management of the home and a turnover of staff had led to inconsistencies in this area. As a result we saw some staff had not had all the required training and most staff had not had planned supervision to support them in their practice. The manager and provider had identified this and had prioritised staff training and the training record showed that training dates had been booked to ensure all staff received the key training they needed. For example one staff member told us, "I can't do any manual handling until I've done the training first but it is booked". This ensured staff had the training to develop the skills to support people safely. Additional training in areas such as diabetes, dementia, and nutrition were included in the training programme to ensure staff had the skills needed to meet people's diverse needs. The manager told us that she was prioritising dates for supervision so that all staff had the chance to reflect on their practice and development. Although staff had not had supervision they told us they had regular support from the manager to discuss any issues or concerns.

We saw people were offered hot and cold drinks throughout the day and staff supported people with their drink where they needed assistance. However, where people were identified as at risk of dehydration the monitoring of risk had not always been consistent. For example for three people we saw their records over the previous weeks had not been completed in full to show what amounts they had managed to drink. More recent records showed that staff were recording fluid intake. However this could have placed people at risk of receiving unsafe care. We brought this to the attention of the manager who told us they would implement a system to check records on a daily basis to ensure people had the required amount of fluids.

People were complimentary about the meals and told us that meals had improved. People said they had a choice of meal and that the quality and quantity of meals was good. We observed a mealtime and saw that staff respected the choices people had made earlier in the day but where someone declined this an alternative was offered. The cook was working temporarily in the home, but was able to tell us which people had specific dietary requirements and we saw this information was documented. Where people needed pureed food or food that had been fortified to increase their nutritional intake this was provided. Staff we spoke with were aware of individual people's support needs and responded to these effectively. For example we saw one person preferred to remove themselves from the table and eat in a different location. We saw the staff member went with them and provided continuous encouragement to them to eat their meal. Another person with a visual impairment who was relatively new to the service was being supported by staff who were assessing the level of help they needed with their meal. Nutritional risk assessments had been carried out to identify those people at risk of not eating enough. Plans identified where people needed their intake and weight to be monitored.

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 told us that staff sought their consent before supporting them. One person told us, "They

always ask before doing anything". We saw staff understood the importance of obtaining consent before assisting people with aspects of their care. Staff we spoke with told us they had received training in MCA and could identify where people gave consent with body language. One staff member said, "I've known people just stand up when I ask if they would like to come with me to the toilet, they may not speak but I know they understand and are happy to cooperate". Staff told us one person refused care interventions but we did not see an assessment of their capacity had been undertaken to ascertain if decisions could be made in their best interests.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us that applications had been made to the local authorities for all people due to the use of coded doors at the home. However not everyone in the home lacked capacity and therefore these applications may not be appropriate. The manager acknowledged that further development of these processes was needed to ensure staff worked in line with the principles of MCA and DoLS.

We saw assessments of people's needs were completed before people arrived at the home and on arrival. Some people were able to confirm their involvement in this process. One person explained how their needs and preferences had been sought; "Staff asked me and my family about what I like and what help I wanted". A relative confirmed that the assessment process included seeking information about the person's history and preferences as well as any specific risks such as falling. Care plans were in place to reflect people's needs and how these should be met. For example we saw plans were in place to support a person at risk of developing pressure sores to use a pressure relief cushion and that the person required their legs to be elevated. We saw that the person was being supported in this way. We saw that any protected characteristics under the Equality Act had been taken into account when assessing and planning people's care. One person told us, "Yes they do have male staff and asked me if I was happy to be supported by a male; I didn't have any objection". We saw people's care records contained information about gender care preferences as well as people's religious needs.

Staff told us that they had a handover between each shift to discuss people's needs, any changes or any actions that were needed. One staff member said, "It helps us identify if someone is poorly, not eating or a bit low in mood; helps us plan their care for that day". Other staff we spoke with told us they considered that communication was good and they had the information they needed on a daily basis to meet people's needs effectively. For example staff told us they identified a person required a hoist and the manager had ordered this and it was due to be delivered the next day.

People and their relatives were complimentary about the ability of staff to meet their needs. One person said, "They know how to help me; they remind me to use my walking frame and to take my time; they are always telling me to use my buzzer instead of going off by myself". Staff had received training in supporting people with dementia and we saw they used their skills to explain and reassure as well as distract a person who was becoming confused and agitated. This approach resulted in the person relaxing and sitting with a staff member having a cup of tea. We observed another person assisting with clearing the tables and helping with the laundry after breakfast as well as taking care of other people. Staff recognised that the person had previously been a carer and that it was important for them to be able to help in this way.

New staff told us they had an induction which included shadowing experienced staff. One staff member said, "I have completed my NVQ level 2, [National Vocational Qualification] so I did the homes own

induction which was more about reading care plans, shadowing staff, safety procedures, and record keeping". Another staff member told us, "I felt well prepared, the manager has been supportive and I can ask other staff anything".

We heard from people that they had access to healthcare professionals such as the doctor, dentist or optician when they needed. Relatives told us that they were kept informed of any changes such as deteriorating health. We saw from people's care records that they were referred to health professionals where their needs had changed. For example we saw a referral to the incontinence team for one person and the district nurses for another person who had fragile skin. Where people had been admitted from hospital for short term care we saw links with the hospital and other health professionals were retained to ensure people continued to receive the care they needed once they had moved into the home. We spoke with a visiting health care professional who told us that staff shared information with them in a timely manner and followed recommendations. They described staff as 'Receptive, knowledgeable about people's needs and helpful'.

The facilities had been designed to take into account the specific needs of people. There was a choice of communal areas for people to include a 'quiet lounge' and a main lounge which ensured people could choose whether to socialise with their peers or not. A cinema room with a large mounted TV enabled people to enjoy films of their choice. A cafeteria had been created where people could sit and enjoy refreshments with their family and visitors. The provider had created a 'garden room'; decorated with wall paper of trees, furnished with a garden bench and a sensor which activated birds singing. Another room had been converted into a sensory room with soft furnishings and sensory equipment. A library was available with a supply of books for people to enjoy. The signage around the home assisted people to orientate themselves. Signage on people's bedroom doors was both visible and person centred for example one person had an Irish flag set in a 3D box which represented their identity. We saw that corridors had been named after local streets so that people could relate to their local community. People told us they had brought in items of furniture and belongings to personalise their bedrooms. There were several areas where people could enjoy art or other activities. A large rear level garden offered people the opportunity to enjoy the outdoors. The premises were spacious which enabled people to mobilise safely.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person said, "The staff have been very kind, they never rush me and they speak to everyone in a friendly way". A relative told us, "The staff are caring; I have seen them spend time with [Person's name] when she's upset and with other people".

We observed many examples of staff demonstrating a caring approach to people particularly where they experienced distress or anxiety. For example, we observed one person becoming distressed in the corridor and saw a staff member asked them what was wrong. The person could not explain what the matter was and as they became more upset the staff member reassured them calmly and asked them if they would like to go for a cup of tea to the cafeteria. We saw this calm, assuring approach, settled the person who took the hand of the staff member and went with them.

There were lots of occasions when staff were kind and attentive towards people. For example a person was showing signs of discomfort whilst sitting at the table. We heard a staff member ask them if they were alright. The person had difficulty in expressing themselves; the staff member said, "Is it your back, have you got some pain?" We saw the person gesture that this was the cause of their discomfort and saw the staff member got a cushion to re-seat the person and checked they were comfortable. The staff member told the person they would get some painkillers and we saw these were administered to ease their pain.

Staff had a good understanding of people's emotional needs and took this into account in their interactions. For example we saw a staff member supporting a person at lunchtime who appeared quiet and a little lost. The staff member told us, "It's their first day here and it can be a little overwhelming, so I'll give lots of support and make myself available so they feel they have someone to talk to".

Staff clearly knew people well; they were able to describe people's histories, characters and preferences. Staff told us that they were always informed when a new person was being admitted and that an initial care plan was available with sufficient detail to guide staff in providing people's care. A staff member said, "We always know something about people so we can relate to them, greet them and help settle them in". We saw that people's care plans contained information about how people liked to be supported.

We saw that staff spent time with people; chatting and sharing jokes and staff told us the manager encouraged them to interact with people. This showed an understanding of the importance of taking into account people's emotional well-being. We saw that people were happy in the company of staff and we saw frequent occasions where staff sat with people in the cafeteria to have a cup of tea and enjoy people's company. People told us that staff would listen to them and make time to help them. Relatives informed us they had positive relations with staff and were always made to feel welcome.

People told us that staff would seek their views on a daily basis about aspects of their care, the meals they had or the events of the day. One person told us, "They always come and ask me if I'm alright, if I need anything or how I want things done, they are good like that". A relative told us, "They are very happy to listen to me; I feel I can talk to the staff or ask them questions about [Name of person's] care". Whilst informal

arrangements were in place to consult people about their views the manager explained that residents meetings had not taken place as planned due to the changes in the management of the home. She recognised that this platform was needed and was arranging a date. Most people we spoke with could not tell us if they had been involved in a review of their care. People's care records showed reviews had taken place but people's comments were not sought. The manager told us she would make people's involvement in reviews more specific to ensure they were central to the review.

People were supported to be independent. One person told us, "I want to work and to help out and feel needed". We saw the person assisting with domestic tasks throughout the day which they told us they enjoyed. Another person told us, "I need to walk a bit more and the staff supports me to do that; they just remind me to use my frame". We saw staff supporting a person who was visually impaired. Staff told us they were assessing how independent the person was and if there were any aids that could be sourced to support them. People's care plans contained information about maintaining their independence such as the personal care tasks they could complete for themselves.

We observed that staff were respectful towards people such as referring to people by their preferred name. People told us staff were always respectful in their manner and tone; one person said, "No raised voices, lovely staff attitude, it shows respect". People were happy that their privacy and dignity was protected, one person told us, "They will knock on the door and when helping me they will cover me and wrap me up nice; I'm never left exposed". We observed staff were discreet when supporting people with their personal care needs such as using the toilet or changing their clothes. A relative told us their family member; "Always looks nice and clean and staff take time to dress her in her favourite colours". We saw the person's preferences in relation to their appearance had been respected and this was detailed in their care plan. Another relative was particularly complimentary about how staff supported their family member during an emergency situation to ensure their dignity was upheld. This demonstrated a compassionate response to the person's predicament.

Good

Is the service responsive?

Our findings

People's needs had been assessed prior to being admitted to the home. People told us they remembered being involved in this process. One person said, "They asked about my health, what support I needed, how I walked and I think they asked about my family and life".

We saw that a 'This Is Me' document had been completed alongside the person and or their family member which contained information about the person's health, social care, religion and preferences. This provided staff with sufficient guidance as to how each person wished to receive their care and support. We saw staff supported people in line with their assessed needs and preferences. Care records were person-centred and included details of people's daily routines, when they liked to get up or go to bed and what people liked to eat and drink.

Staff showed an understanding of protecting people where factors such as their health condition [dementia] might increase their vulnerability. Some people had formed friendships and bonds with other people. We saw staff understood the need to support people without placing them at risk. We heard from staff that where people's capacity to make such decisions was limited, that family members had been consulted about decisions and the best way to support a person.

Care plans included the recommendations of other health and social care professionals to ensure that care was responsive to people's needs and recognised any risks to their welfare. We saw that healthcare professionals were consulted as and when people's needs changed and that people received support in line with recommendations. For example for one person keeping their legs elevated as suggested by a nurse. People's care needs and any associated risks were regularly reviewed.

We saw information was accessible and could be produced in different formats to meet the needs of people who lived at the home. For example, the statement of purpose which provides people with information about the home and the provider's complaints procedures were available in other written formats which included large print.

People told us that they enjoyed some daily activities. Relatives were complimentary about the social aspect of the service in terms of staff spending time with people. They felt their family members benefitted from the positive interaction with staff and their peers. One relative said, "It's important they are not isolated and I think the staff do a nice job of keeping people involved, chatting to them and socialising". We saw people enjoying quizzes and puzzles, and people told us they had played skittles and dominoes. Other people were enjoying art. One person showed us their book and how they had coloured in the scenery they said, "I do like to do a bit now and then". We saw other people looking through a variety of photographs of the local area and reminiscing with their peers and staff. One person told us, "I have enjoyed keep fit to music, someone comes in and does that, it's good". We saw people using the cinema room to watch films. We observed spontaneous social activities taking place in the cafeteria where people enjoyed the opportunity to sit with staff and chat whilst having refreshments. Whilst the facilities available included a library, garden room and sensory room these had not yet been fully utilised but we were told arrangements

would be made so that people could enjoy these on a one to one or small group basis. At the present time staffing levels had not been flexible enough to provide this aspect of person-centred care. The manager told us they recognised the need to structure and organise a range of activities and that they were planning to appoint an activities coordinator and produce activity plans and posters.

People told us that they had been asked about their religious needs as part of their care planning and that a service took place at the home in which they could participate. Staff told us that people's religious or cultural requirements would be catered for but that they did not currently support anyone from different ethnic groups. The manager informed us part of the on-going development of the home would be exploring the amenities within the local community to ensure people could stay in contact with their communities or culture where this was needed.

People told us that they knew how to make a complaint and they felt confident it would be listened to. One person told us, "I did raise a concern and they did something about it". Another person said, "I haven't made a complaint but I know how to and I think I have a copy [of the complaints procedure] somewhere that they [staff] gave me". The manager informed us that everyone had a copy of the complaints procedure with details of how to make a complaint. We saw systems were in place to record and investigate complaints and provide feedback to the complainant. The provider's monthly visit report included the review of any concerns or complaints raised and we saw that people were asked if they had any complaints.

The provider had considered the needs of people who required end of life care. Although they had not provided support to anyone who was at the end of life we saw they had a policy in place which covered the key areas of this care. We also saw that they had made links with their local hospice to source additional training for staff in providing this care. This meant that should people require end of life support in the future, there were plans in place to provide this.

Requires Improvement

Is the service well-led?

Our findings

Prior to this inspection concerns were shared with us regarding inconsistent management. The provider had notified us about changes to the management of the home. The home was registered in July 2017 and opened in September 2017. At that time there was a Registered Manager in post who left the service after a couple of weeks. A second manager was appointed but left in January 2018. The Managing Director of SCL Care Ltd explained the reasons behind the management changes and we saw these changes were unavoidable.

A requirement of the service's registration is that they have a registered manager. The Managing Director of SCL Care Ltd was confident the manager in place at this inspection had the right experience and qualifications to manage the home. The manager had worked in the home for a few weeks prior to our inspection and told us she shared her time between this and another of the provider's homes. The provider told us they supported the manager by being present in the home in her absence and being on call to offer advice and assistance if required. The provider had submitted an application to register this manager with the Care Quality Commission.

Although the provider was supporting the manager by spending time within the home in her absence, there was no designated deputy or clear management team to ensure that the care and support provided to people is guided by good practice and management support. Staff described the current manager as 'proactive' and 'hands on'. One staff member said, "She gets things done, she knows the service users and helps us out on the floor, we can always ask her for help". Another staff member said, "Things have improved a lot in the last few weeks, but to maintain that we need a full management team". The provider told us they had plans to develop the management structure by creating a deputy position.

The findings of this report evidenced that inconsistent management had affected service delivery. Staff felt that there had been inconsistent leadership and direction to them. Staff training targets had not been met and planned staff supervision had not taken place due to ineffective management at that time. There had also been an issue with previous staff swopping shifts without authorisation and not delivering the required standard of care. Staffing levels had been an issue due to staff not arriving for work and being unable to find cover at short notice. The provider had taken action and dismissed staff due to being unreliable which had led to a high turnover of staff.

The manager explained to us the challenges they had faced since they came to the service. They were able to demonstrate they had taken immediate action to structure the rotas so that shifts were covered by a balance of those staff with the right skills and expertise to meet people's needs. They had also strengthened the admissions criteria to ensure they could meet the higher dependency needs of people discharged from hospital until such time the core team of staff and training was in place. Staff training had been prioritised so that staff had the key training they needed to care for people safely. Staffing levels had been improved via the use of staff from other homes. They believed staff provided a good quality of care but wanted to improve the managerial oversight and stability for people and staff. They recognised constant changes made it difficult for people to have confidence in the service. The provider was recruiting to care staff and a cook

vacancy. They were also looking to increase the domestic hours within the home. We saw from rotas that in recent weeks staffing levels had improved with the use of staff from the providers other homes, and had been maintained at the required levels to meet people's needs safely. However the service still needed a full complement of staff with the platforms in place to ensure staff have guidance and support to maintain a good standard of care delivery to people.

The manager conducted audits to ensure people had received effective care and that the environment was safe. We saw there were a number of audits in place to assess the quality of the service provided and drive improvement, for example, medication audits, analysis of accidents and incidents and environmental checks. However we identified these needed further improvement as the provider's audits did not identify the shortfalls we found during the inspection. For example we found gaps in records related to the monitoring of those people at risk of dehydration and those people at risk of developing pressure sores. We also saw there had been a number of falls but there was a lack of analysis of falls to help identify any themes or patterns which might help to reduce these. There was a system for escalating these reports to the provider and both the manager and provider had regular communication via meetings and electronic devices to ensure action was taken with any identified tasks or targets. The manager and provider had identified other areas that needed further improvement such as establishing residents meetings and staff meetings and we saw they had plans to arrange dates for these.

As part of the quality assurance people confirmed that they had been asked to provide feedback on the service in the form of surveys. We saw the results of these were positive and displayed in a pictorial format for people to access. Staff described an open culture with the manager and provider arranging meetings with them to address the issues that were evident within the home. Staff said the provider was keen to provide assurances particularly when there was a turnover of managers.

The manager told us they shared the same vision as the provider for the future of the service. This was to establish good quality care to people within an environment that was designed to meet their specific needs. We saw that in order to improve the quality of people's lives at the home a number of initiatives had been taken to design facilities suited to the specific needs of the people.

The provider had established links with other agencies to gain support or share best practice to ensure the quality of care and support was continually improved. They worked with the local authority to provide respite beds to people who were discharged from hospital but who were too poorly to return to their own homes. The local authority reviewed this aspect of the service and told us they had no concerns. There was the beginnings of joint working with the local hospice to provide training that would enable staff to promote and raise the level of end of life care to people when this was needed.

The provider had notified us about events that they were required to by law. They were also aware of the requirement to have a registered manager at the home and told us they were in the process of submitting an application. Staff we spoke with were aware of the whistle blower procedures and how to escalate any concerns about people's care. The provider has been receptive and responsive to managing any concerns raised with them.

As this is the first inspection for this location the provider will be required to display the Care Quality Commission rating following this inspection.