Barchester Healthcare Homes Limited

Badgeworth Court Care Centre

Inspection report

Badgeworth
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Date of inspection visit:
20 August 2017
21 August 2017
22 August 2017

Date of publication:
18 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20, 21 and 22 August 2017 and was unannounced. Badgeworth Court Care Centre provides accommodation for 65 people who require nursing and personal care. 56 people were living in the home at the time of our inspection. Badgeworth Court Care Centre is set over two floors. The home has three units which support people with different needs. Each unit has a lounge and dining room with an adjacent kitchen. People have access to a garden, coffee area as well as a hair salon.

There was no registered manager in place as required by the provider's conditions of registration. 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. However an interim manager was in place who was planning to submit an application to CQC to become the home's registered manager until a permanent manager was recruited to ensure the provider would meet their registration requirements.

We inspected the home as we had received concerns about the quality of service being delivered to people who lived at Badgeworth Court Care Centre. These included concerns about the cleanliness of the home, the quality of food available, the support people received to eat as well as the number of staff available. This inspection was also prompted in part by the provider's notification to CQC of a significant event. The information shared with CQC about the incident indicated potential concerns with the end of life care people received. This inspection examined those concerns and reported on the findings in the caring and well-led questions. This incident is subject to a separate coroner's inquest and as a result this inspection did not examine the circumstances of the incident.

Our previous comprehensive inspection of the home was completed on 5 February 2016 and the home was rated 'Good' overall. At this inspection we found improvements were needed across all five domains and the provider had not maintained their previously awarded 'Good' rating. This is the first time the service has been rated Requires Improvement overall.

The provider had identified shortfalls in the service people received prior to our inspection.
A new interim manager had been allocated to the home by the provider to assess the care being provided and drive improvements across the home. They were being supported by specialist advisors from the provider as well as the regional manager. People, relatives and staff told us they were not always confident the improvements would be made, sustained and embedded in the home.

We found the interim manager and provider representatives understood the improvements that needed to be made to the service. They had started putting arrangements in place to reduce the impact the service shortfalls would have on people whilst the provider was completing their improvement plan. However we found these arrangements were not always effective and people did not always receive quality care whilst the provider's monitoring systems were being embedded and improvements were being made.

We found that people who were at the final stages of their life could not always be assured that they would receive personalised end of life care. Delays in planning people's end of life care meant people were not promptly given support to make decisions about their care preferences. Staff might therefore miss the opportunity to tailor people's care at the end of their lives to their wishes.

People were supported to access health care services when their medical needs had changed and received their medicines as prescribed. We received mixed comments about the quality of food people received. We found that people's dietary needs were catered for however people who lived with dementia were not always supported to have a positive meal time experience.

People living with dementia did not always receive personalised support that met their needs and were not always given opportunities to have a meaningful and stimulating day. People and their relatives were positive about the staff who cared for them. Staff ensured that people's dignity and privacy was respected.

The provider did not keep a comprehensive record of the care people required and had received and the decisions taken in relation to their care and treatment. Action was being taken to review and update people's care plans.

The provider was actively recruiting managers, nurses, care and non-care staff including housekeepers and an activity coordinator. However, people who used the service, their relatives and staff told us they were concerned the staff turnover and reliance on agency staff meant that people could not always be confident their care needs would be met. We found evidence that people had not always received personalised care that met their individual needs. This was confirmed by information from people and their relatives and we made observations to support this during the inspection.

The interim manager had put systems and meetings in place to capture the views and concerns of relatives. Time was needed to ensure relatives' complaints would be resolved effectively in accordance with the provider's complaints process.

Staff shared with us concerns about the support they had received. The interim manager had put plans in place to ensure people were being cared for by staff who had been adequately trained or supported to meet their needs. Systems were being put into place to gain the views of relatives and staff and improve communication and assess the quality of the service being provided.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulation 2009. You can see what actions we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not always safe.

People and their relatives were not always sure if there would be enough staff to support them. The interim manager was reviewing the staffing levels and deployment of staff across the home to ensure people were safe and familiar with their needs.

Staff were aware of people's risks and people felt safe living in the home.

People received their medicines as prescribed. Improvements were being made in the management and stock control of people's medicines.

The recruitment records of staff were being reviewed to ensure people were being supported by staff of good character.

Is the service effective?

Requires Improvement

The service was not always effective

People living with dementia did not always receive personalised support that met their meal time needs.

Improvement was needed to ensure people's records in relation to care decisions and their consent to care showed how people's rights had been upheld in accordance with current legislation.

Plans were in place to ensure people were being cared for by staff who had been adequately trained or supported to meet their needs.

People were supported to access health care services as required.

Is the service caring?

Requires Improvement

The service was not always caring.

People's end of life care had not always been planned in accordance with national best practice guidelines and people might therefore not receive end of life care that met their needs and wishes.

We saw staff interactions with people were positive and caring. People and their relatives were positive about the caring approach of staff who supported them.

Staff respected people's dignity and privacy when supporting them with their personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst the home provided some activities, these did not always reflect people's individual social and recreational needs.

People's care plans did not always reflect their current needs. Staff might therefore not always have all the information they need to know how to provide individualised care to people.

The interim manager had put systems and meetings in place to capture the views and concerns of relatives. Time was needed to ensure relatives' complaints would be resolved effectively in accordance with the provider's complaints process.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had identified shortfalls in the service people received and a new management team was in post to support staff and to improve the service.

Systems were being put in place to monitor the service quality and mitigate risks to people not receiving safe care. However, improvements were needed to ensure these systems would effectively drive improvements and reduce risks to people.

Staff and relatives had expressed concerns about the leadership of the home, however some expressed confidence in the new management team.

Systems were being put into place to gain the views of relatives and staff and improve communication.

Badgeworth Court Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 20, 21, 22 August 2017 and was unannounced. The inspection team consisted of an inspector, inspection manager, a specialist advisor in end of life care 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. The expert had experience and knowledge of caring for older people.

Before the inspection we reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

During the inspection we spent time walking around the home and observing how staff interacted with people. 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 spoke with 13 people and 13 people's relatives and visitors. We looked at 14 people's care plans and associated records. Following our visit a further five relatives contacted us to share their concerns about the care their loved ones received.

We also spoke with 15 care staff, five nurses (including agency nurses), a housekeeper, two kitchen staff, the maintenance person, the clinical development nurse, peripatetic manager, regional director and interim manager. We looked at files relating to staff development and recruitment. We also checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the

management of the home.

Requires Improvement

Is the service safe?

Our findings

We received a mixed response from people, their relatives and staff when we discussed the staffing levels at the home. The home relied on staff working across all units within the home and a number of agency staff to support people during the recruitment and induction of new staff when staff had terminated their employment at the home. Staff told us that they had been under considerable amount of pressure due to staff turnover to make sure people remained safe and were being cared for. We received comments such as "I used to feel so proud to work here, but not anymore" and "I'm hanging in there.'' One staff member felt their professional development had suffered as their attendance on courses had been occasionally cancelled to ensure there were enough staff left in the home to support people.

Relatives shared with us their concerns about the inconsistency of staff and the staffing levels in the home and gave us examples of occasions when the home had not been fully staffed due to unplanned and unforeseen staff absences. One relative said, "They have needed more staff on occasions. The staff here are over worked but always very kind." Another relative wrote to us and said, "Sadly the staff are overstretched and the residents are frequently left to their own devices." Another relative told us, "There have been a lot of changes in the staff and I'm not sure who knows what about my mum. I have had to explain how she needs to be supported several times. It's been a big worry to me and my family." The interim manager was aware of their concerns and told us that where possible they used regular agency staff so they were familiar with the people they cared for. The agency nurses we spoke with had worked at the home for some time and we found during shift handover meetings they could describe people's needs and preferences.

We heard of several examples where staff cover could not be found at short notice. Although the interim manager had ensured people remained safe they did not always receive individualised care that met their needs as we reported on in more detail in the domain of 'Is the service responsive'. Improvements were needed to ensure effective arrangements were in place so that staff would always be available to cover last minute unplanned staff absences.

Throughout our inspection we observed staff responding to people's call bells promptly. The provider had installed a new call bell system and the interim manager was also planning to use the new system to monitor staff response times to further improve the deployment of staff. We spoke with the interim manager about the staffing concerns raised with us and we they told us they were reviewing the deployment of staff and trialling a new staff shift allocation according to staff members individual skills and experience. The senior management team were also reviewing the use of the provider's care dependency tool which they used to determine the staffing levels of the home. The interim manager was actively recruiting and inducting qualified nurses, care staff and non-care staff to ensure people received safe and effective care from staff who were familiar with their needs. For example, hostesses were being recruited to support people around meal times; this would allow care staff to spend more time supporting people with their personal care.

Nurses and staff were also being supported by a clinical development nurse and a peripatetic manager until an established team including a clinical lead and deputy manager were recruited and they had developed a good understanding of people's needs and the processes of the home. The interim manager told us that a

floating staff member had been made available after 8pm to support staff across all the units. We will review the progress and impact of the recruitment of the new staff as well as the staffing deployment and levels at our next inspection.

On the days of our inspection we found that people's medicines were being stored in accordance with national guidance. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control. We observed safe and personalised practices in the administration people's medicines. For example, medicines were administered to people according to their individual needs. People were addressed by their name and staff explained to them reasons why they needed their medicines.

The provider had identified as part of their Quality Improvement Review completed on 6 July 2017 that some improvements were needed in the safe management of people's medicines. The clinical development nurse told us that improvements were being made to ensure people's Medicine Administration Records (MAR) would always be signed when they received their medicines. They had also completed a medicine stock review and had returned significant amounts of extra medicine stock to the community pharmacy. The clinical development nurse told us work was still being undertaken to ensure the correct amount of medicines would be available to people when needed. They told us care plans of medicines which may be used occasionally (such as when people were feeling anxious) were being reviewed to ensure staff had clear guidance of when these medicines should be administered.

During our inspection we saw progress was being made against the medicine improvement plan. For example, people's MARs we looked at had been completed accurately and showed that people had received their medicines as prescribed. 'Do Not Disturb' tabards were consistently worn by staff during the medicine rounds to reduce the risk of interruptions which could result in medicine errors being made. After our visit the interim manager provided us with an update of their medicine improvement plan which showed improvements continued to be made. For example, all staff administering medicines had their competency assessed to ensure they worked in accordance with the provider's medicine management policy.

People were protected from abuse as staff who supported them had a good understanding of recognising signs of abuse and protecting them. Staff had been trained in recognising types of abuse and understood the provider's whistleblowing and safeguarding policy. Staff could access the provider's whistleblowing hot line and were aware of external safeguarding organisations where they could discuss any concerns. They told us the actions they would take if they were concerned about someone's safety or wellbeing. One staff member said, "I would not hesitate to report it if I felt a resident was being hurt by anyone both physically or mentally".

People and their relatives were confident that staff would keep people safe and people told us they felt safe from abuse living in the home. We received comments such as "It is good here, staff make me feel safe", ''We feel my aunt is safe here, we have no concerns about her safety", "I have no doubt that my father is safe here" and "Yes. It is much safer here than at home for an old codger like me". The interim manager was working with the appropriate safeguarding authorities on recent safeguarding allegations to ensure people remained safe while living at Badgeworth Court Care Centre.

We saw risk to people had been identified and plans had been put in place to keep people safe. These covered, for example, falls, choking and skin deterioration. Where people were identified as being at risk of falls we saw there were strategies in place to either reduce the risk of falls or the risk of injury in an event of a fall. For example, low beds, crash mats and floor sensors were in place as required to keep people safe. We saw staff responded promptly when one person's floor sensor was activated to ensure they would be

supported safely.

Risks associated with assisting people to mobilise and transfer using equipment had been assessed and was being managed. Staff told us and records confirmed they had received training in moving and handling to support people who had reduced mobility to safely use a hoist. One person who required a hoist praised the approach and skills of staff when transferring them in the hoist. Maintenance records showed hoisting equipment and slings had been checked and serviced by external contractors in accordance with the manufacture's guidelines to ensure equipment was fit for use. We spoke with a community physiotherapist who told us they had been asked by the service to re-assess a person's moving and handling needs and had observed staff undertaking a complex hoisting task. They told us "I found staff to be very skilled, they worked safely throughout and kept on reassuring the person whilst they supported them."

When safety incidents occurred, these were reported and recorded by staff. Prompt action was taken to ensure similar incidents would not take place. For example, staff had responded in a timely manner when choking incidents had occurred and referred people to the speech and language therapy team for further assessment.

A recruitment system was in place to ensure that suitable staff were employed to support people. The professional working histories and qualifications of agency staff had also been sought and checked prior to them working with people at Badgeworth Court. We looked at the recruitment documents of five new staff which had been carried out by the previous manager. New staff had been requested to complete an application form including their employment and medical history. Employment and criminal checks had been carried out on all new staff. The interim manager told us they had identified that recruitment records required improvement prior to our inspection. For example; ensuring that gaps in employment histories that had been explored would be recorded. They were addressing these gaps as well as assuring that all the required checks and recruitment documents would be in place for all future new staff.

On the days of our inspection the home was clean and tidy; however relatives had expressed concerns to CQC about the cleanliness of people's bedrooms. They told us the cleanliness of their relative's bedrooms had been variable recently. We were told that due to a recent shortage in staff, the housekeepers had been asked to prioritise their cleaning tasks to key areas of the home. The interim manager was actively recruiting new housekeepers and would be reviewing their work schedule to ensure there was a continued flexible approach in the cleaning management and upkeep of the home. Housekeeping staff would also be asked to embark on a schedule of deep cleaning of people's bedrooms as well as the home's upholstery and carpets.

The cleanliness and maintenance of the home was inspected by the interim manager on their daily walk around the home. Any concerns found were raised at the daily heads of department meetings. Most staff were knowledgeable about infection control procedures and embedded their understanding into their care practices when supporting people. However improvements were needed to ensure staff would consistently adhere to safe infection control practices to reduce the risk of cross contaminations. For example, we observed not all staff wore aprons when supporting people with personal care or washed their hands afterwards.

Fire safety systems and fire risk assessments were in place and routinely checked to ensure people remained safe in the event of a fire. The maintenance manager told us fire drills were being completed more frequently to ensure all new staff would become familiar with the evacuation procedures. These measures ensured that the provider was taking action to protect people from the risks associated with a fire.

Requires Improvement

Is the service effective?

Our findings

People were encouraged to maintain a balanced diet. We observed meals being served in the dining rooms on each unit. People were offered a choice of drinks and meals or could choose from a supplementary menu which included omelettes and jacket potatoes. The kitchen was made aware of people's dietary needs and preferences and catered for them accordingly such as people who requested a vegetarian diet. People at risk of malnutrition were provided with fortified meals and drinks. Thickened drinks and pureed food was provided to people at risk of choking to ensure they received sufficient nutrition. Pureed diets were made in the same two choices of main meals.

Some people living with dementia found it difficult to make meal choices from the main menus. We saw staff showed them the plated meals to support them to make their own choices and assisted people by explaining what the meals were.

We received mixed comments from people and their relatives about the meals that were offered. Some people said positive comments such as "I like the food here", "Delicious, I have no complaints" and "The meals are nice. We get lots of choice." However other people and their relatives felt the quality of the meals had deteriorated and some of the meals didn't always look appetising. One relative stated the quality and the presentation of the meals were "hit and miss". The interim managers told us they were working with the head chef and reviewing the menu options. This included sharing people's views of the meals served in the home with the head chef who would be attending the relatives and residents meetings and be part of the resident of the day process to ensure future menu changes would meet the needs of people. We will be checking at our next inspection whether this proposed action had led to improvements in people's satisfaction with the quality of the food available.

We observed most people enjoyed eating their meals in one of the dining rooms; however we noticed that people had to wait for a long period of time before they were served their meal. The long wait impacted on people's enthusiasm to eat their meal. For example, we saw some people living with dementia becoming distressed and frustrated and found it difficult to settle sufficiently to enjoy their meal. Some people had become too distressed to remain seated despite staff's attempts to support them and walked away from their food. We could not be assured that they had had enough to eat and did not see staff offering them alternative meal options from the snacks menu that might meet their preferences.

Some people required physical assistance from staff with their eating or drinking or if they became tired. We observed staff being attentive to people's needs and prompting them when necessary to eat a bit more. Although we saw that lipped plates were provided to help people to eat and soup was put into cups for people who found this easier; this was not always sufficient to support people living with dementia who preferred to eat with their hands. On the first night of our inspection we found finger food was available for people but this was not the case during lunch time on the second day and we saw people trying to scoop soft food with their hands. We did not see staff offering them food that they could manage easier by hand. We spoke with the assistant chef who told us that finger food was not always available at each meal and they would look into making this available at each meal.

Following our visit to the service we also received concerns from five relatives who told us they were not always assured that their loved ones were receiving sufficient support to eat. Records showed nutritional assessments had been carried out as part of people's initial assessments which showed if people had any specialist dietary and nutritional needs. People's weights were recorded and where needed advice had been sought from the relevant health care professionals. However, where people had poor appetites and were at risk of weight loss, their recommended nutritional intake and food charts had not always been completed consistently. It was therefore not possible for nurses to evaluate people's care and determine whether the personalised nutritional plans they had put in place had been delivered for people.

People living with dementia did not always receive personalised support that met their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had a basic understanding of the principles of the Mental Capacity Act. 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. Staff demonstrated that they sought people's consent before they provided people assistance with their care needs. They told us if people were unable to express their views, they gathered information about people from their relatives to ensure they understood people's preferences. People's care plans prompted staff to ensure they provided people with choices about their day to day care and support.

We found the records relating to capacity assessments and best interest decision making were not consistent. For example, one person's care plan evidenced best interest decision making in relation to their behaviour support which included health professionals and family members. Another person's records however did not show whether they had consented to the use of safety bed rails or lacked the capacity to make this decisions and required the service to complete a capacity assessment and best interest decision.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). When required the interim manager had applied to the local authority to gain authorisation to deprive people of their liberty, where alternative methods of support were not viable. Staff could describe how they supported people in the least restrictive manner. However, people's care plans did not always provide staff with the information they needed to know what restrictions had been placed on people to keep them safe and how to support them to maximise their freedom.

The provider did not keep a comprehensive record of the care people required and the decisions taken in relation to the care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager told us they had identified that improvements needed to be made to enhance the daily experiences of people living with dementia. Staff training was planned for 6 and 7 September 2017 to support staff to know how to 'enhance the dining room experience' and develop 'understanding of activity and meaningful occupation'.

People and their relatives felt confident in the skills of the staff who supported them. However, staff felt that the level of training and support that they had received had reduced during the last year. For example, staff expressed mixed feeling about the support they had received. One staff member said, "When I started working here I had very little support, no probation meetings. I had to learn on my feet" whilst another staff

member said, "The support and training we get is not as good as it was but its ok. I know I can speak to the manager or a senior if I need some advice or I'm not sure about something."

Since being in post the interim manager had reviewed the current training and support levels of staff. They shared with us the staff training matrix which showed whilst most staff had received mandatory training in core health and social care subjects such as moving and handling training; other staff still required updates in their training. Additional training was being sourced and planned for those who needed training or to be refreshed in their knowledge. For example; in dementia awareness and training in the management of people's skin care to prevent pressure ulcers.

Nurses had been supported to revalidate their nursing qualification and professional registration. The training profiles of the home's nurses and agency nurses indicated they had received core mandatory training and some additional clinical training in subjects such as wound management and first aid. However others had not completed recent courses in subjects such as catheter care or operating syringe drivers to enable them to administer medicines by a continuous flow of injected medicines under people's skin. The service involved community nurses when needed to support with people's clinical care when their nurses did not have the required training. The interim manager told us that plans were in place to ensure that all nurses had the training and skills needed to meet the needs of people in the home effectively.

The interim manager recognised that the monitoring of the work based skills and training of nurses and care staff was an area that required addressing to ensure they had the skills required to support people with their personal care and nursing needs. The interim manager and key senior staff members were observing and assessing the skills and knowledge of staff to ensure staff met the required standards of care. They supported and mentored staff where gaps in their knowledge were identified. Plans were in place for all staff to receive regular professional support meetings and for nurses and senior carers to receive clinical supervision to discuss people's clinical needs, refresh their knowledge, share and use the provider's clinical resources.

When staff had observed changes in people's health and well-being they sought advice and support from healthcare professionals. A GP visited the home weekly to assess new people who had moved into the home and review those who required medical support. One person told us, "I can see the doctor if I do not feel well. They will organise it." Health care professionals were mainly positive about the support people received in the home and felt that staff referred people to them appropriately.

Requires Improvement

Is the service caring?

Our findings

We found that people who were at the final stages of their life could not always be assured that they would receive personalised end of life care. Not all staff had received end of life care training and staff we spoke with could not describe how they would recognise the possibility that a person might die within the coming days. This meant opportunities could be missed to support people to communicate their wishes for their care at the end of their life and to be involved in decisions about their pain and symptom management.

When people had been identified as being in the end stages of their lives action had not always been taken to ensure end of life care plans were put in place. People's end of life wishes were not promptly documented so that staff could tailor people's care to meet their individual preferences and deliver compassionate care. For example, one person had been reviewed on 9 August 2017 by a nurse from the community Care Home Support Team with a nurse from the home. This review identified that the person required end of life care. A care plan was completed by the community staff stating specific recommendations the home needed to complete, this included completing an end of life care plan. During our visit on 22 August 2017 the peripatetic manager was assisting a care practitioner to complete the person's end of life care plan. This care plan had not been completed within the 13 days since the Care Home Support Team had made the recommendation and peripatetic manager told us the hospital had identified the person required end of life care three months ago.

Another person's records had been reviewed by the GP on 16 August 2017 and had advised staff that the person was at end of their life. The GP had prescribed anticipatory medicines this would ensure medicines for end of life symptom control was available for this person so that nurses could give this medicine if required without unnecessary delay. However at the time of our visits this person still did not have an end of life care plan in place to document their decisions about their care at the end of their life. Delays in planning people's end of life care meant people and those close to them were not given support and opportunity to make decisions about their preferences for end of life care. People were at risk of not being pain free; for example there were no records or assessment tools in place for one person who was receiving end of life care to indicate how to manage their pain or how they may express their levels of pain so that nurses would know when to administer their pain medicine.

The clinical development nurse told us the service had sought guidance from the local hospice or community palliative support team for additional advice. However this had not been recorded to ensure that staff would know what support people required in accordance with best practice for end of life.

People's end of life care had not always been planned in accordance with national best practice guidelines and people might therefore not receive end of life care that met their needs and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who were polite, kind and respectful. People and their relatives commented that whilst the home had been through some changes, staff had remained caring and passionate while supporting people. Most relatives felt that staff had worked hard to ensure that people were supported by

staff who understood their support requirements and recognised that improvements were being made to the management of the home.

People and relatives expressed their gratitude about staff and said comments such as "They are all treasures. They can't do enough for me", "I have a feeling that their (the staff) morale is very low, but they keep doing a wonderful job", "The girls' are so caring. You feel that they are really interested in their jobs" and "It's so good to know that I don't have to worry about [name of person]. She's the light of my life and I know she will be looked after."

We saw examples of staff caring for people with gentle, compassionate and respectful approaches. Staff addressed people by their first names in a friendly and respectful way. People appeared relaxed and comfortable around staff. Staff responded quickly when they saw a change in people's emotional well-being or behaviour. For example, one member of staff acted promptly when a person became upset and gave them reassurance by talking gently to them. The person did not respond to the member of staff verbally but showed their well-being by holding onto the member of staff's hand and stroking it whilst walking with them. Staff demonstrated good listening skills and allowed people time to speak at their own pace. They adapted their approach to ensure that people understood their instructions and listened to people patiently.

There was a relaxed but subdued atmosphere at Badgeworth Court Care Centre, although we observed many warm and genuine interactions between staff and people who lived in the home and their relatives. The interim manager was aware that the atmosphere of the home sometimes varied and was aware of staff who had a positive impact on people. They had recognised the subdued atmosphere of the home on one of the days of our inspection, and had moved one member of staff to another unit to help uplift people's spirits. The interim manager shared with us copies of correspondence that praised the staff and the improvements being made in the home.

Staff knew people well and could tell us about people's individual likes and dislikes. We observed them sharing their knowledge about people with new and agency staff. Staff were attentive to those people who were frail or at the end stages of their life. Staff ensured that they were comfortable, pain free and not distressed. Staff responded well to people's direct requests for support. For example, a nurse immediately responded to the request of one person who asked to have a glass of milk with their medicines. Staff were attentive to people's well-being such as asking them if they were hot or cold and helping them to adjust their clothing or putting on a fan according to their requests.

People's dignity and privacy was valued. Staff knocked on people's bedroom doors before they entered and helped people with their personal care behind closed curtains and doors. We saw staff talking to people in a confidential manner if they were amongst other people. Staff provided us with examples of how they supported people with dignity and encouraged them to be independent where possible.

Requires Improvement

Is the service responsive?

Our findings

People living with dementia, who could find it difficult to make sense of their world, did not always have opportunities for meaningful engagement during their day. We observed people sitting in the lounges and dining areas sleeping or watching TV throughout the day with little proactive social interaction from staff. People did not always have access to objects that they might find interesting and meaningful structured activities were not provided on the days of our visits which people could participate in. People told us they would like to sit in the gardens or have trips into the local community.

People and relatives raised concerns with us about the lack of activities and opportunities for people to socially engage with other people other than their visitors. There was little recorded evidence that people had been provided with the option to join in activities in the home or have access to individual social interests and hobbies. Some people told us they felt bored and lonely. One person said, "There is not a lot to do around here. The carers are pleasant but they don't have the time to sit and chat with me." Another person said "I am short of someone to chat to because everyone here goes to sleep all the time" and another said ''There really is not much choice in the activities here''.

Whilst staff engaged with people in a caring manner when supporting them with tasks such as their personal care, we saw there were at times limited social and proactive interactions between some staff and people. For example, staff missed opportunities to socially engage with people while they waited for the hot food trolley to be delivered to their unit at lunchtime. Staff also did not consistently use a small white board and pen to communicate with one person who was hard of hearing when they became distressed as noted in their care plan. We saw the person was reassured and was less anxious when staff used the white board to help communicate with them. During the second day of our visit staff spend more time with people in the dining area during the afternoon and we saw people responded positively to this interaction smiling and chatting with staff.

The service did not consistently respond promptly to people's needs. On the days of our inspections we saw people in their bedrooms with call bells placed within reach and staff answered their calls for assistance promptly. However we noted that some people did not have the ability to use or have access to a call bell system in the lounge areas and relied on staff to check if they needed support. We found when people were left unsupervised in communal areas the monitoring arrangements varied on each unit and people were not always routinely checked to ensure staff would be available if they needed support. During our inspection we saw a number of staff periodically monitoring people in the lounges of the De Clare and Norwood units. However we observed that some people were at risk of not being frequently checked in the communal areas of the Selwyn Payne unit especially in the evening when staff were busy supporting people with their personal care in their bedrooms. For example, staff were not available to reassure one person who became distressed about the tidiness of the lounge. The person started to tidy the lounge area without using their walking frame which put them at risk of falling. We also had to call staff to assist another person when they became distressed in the communal area in the De Clare unit and all staff on the unit where occupied.

Staff told us they tried to visit the lounge between supporting people in their bedrooms or could call for

additional support in an emergency or when people required the assistance of a second staff member such as being regularly turned in their bed at night. However they told us they did always have time to spend with people and one staff member told us 'There aren't enough staff for person-centred care." Staff shared with us the impact of having a period where there had been constant changes in staff. For example, they told us it was not always clear who had responded when they had raised concerns about changes in people's well-being. They told us inducting agency and new staff members on to the units had been time consuming and had impacted on their ability to respond to people's needs in a timely manner.

People did not always receive person-centred care appropriate to their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager had recognised that people's days were not always meaningful or social and was recruiting an additional activity coordinator to ensure there was a wider range of personalised and group activities available to people. The provider's dementia care specialist had also recently visited the home and assessed how staff were supporting people who lived with dementia including their approach and how the environment supported them to remain safe as well as providing opportunities for social and recreational engagement. The availability of rummage boxes, improving the signage and providing dementia friendly environment were recommended as well as further staff training in dementia awareness. We will follow up on the implementation of these recommendations at our next inspection. A new call bell monitoring system was also being installed. This would enable the interim manager to monitor the response time of staff when people pressed their bells for assistance so that action could be taken to improve the response time if required.

People's care plans did not always reflected all people's current care and support requirements. Staff might therefore not always have all the information they needed to know how to provide individualised care to people. For example, some people lived with diabetes and required the support of staff to identify when they might become unwell. Staff were able to describe the signs that would alert them that people's blood glucose levels were too high or low and the action they needed to take to mitigate the risk of ill health. However this guidance had not always been recorded and staff could not always rely on people's care plans to know how to support people to manage their diabetes effectively.

People's care records did not always reflect the care and treatment people had received. For example, everyone living in the home had been screened for the risk of developing pressure ulcers. Where people had been assessed as being at high risk, a tissue viability care plan had been put in place to guide staff on how to reduce the risk of people's skin from deteriorating. This included the use of pressure relieving equipment and supporting people to regularly change their position to relieve the pressure on their skin. People had also been prescribed topical creams to keep their skin moisturised. However, people's topical cream charts had not always been completed to show when people had been supported to use their creams as prescribed. When damage to people's skin had occurred, nurses had sought advice from tissue viability specialists. Whilst we found that people's wounds were healing, wound assessments and treatment plans for three people had not been completed in accordance with the provider's requirements. Nurses could therefore not evaluate whether people had received the individual treatment they needed to ensure their skin would remain healthy.

Some staff felt that the variations in people's care records were due to the numbers of new and agency staff who were not clear of the provider's expected standards in the management of people's care records. For example, we spoke to two staff members who gave different accounts of where people's blood glucose readings should be documented. And we saw for one person it was recorded in two different places and nurses could therefore not judge from the provider's required record whether the monitoring had taken

place for this person. We observed staff appropriately supporting people living with dementia who became distressed and upset; however there was limited recorded information and behaviour management care plans on how to support those people whose behaviour might challenge. One staff member explained that there had been a lot of new changes imposed in the management and recording of people's care needs. They said, "We have been bombarded with new paperwork and new forms. It has been hard to keep up, especially if you are off duty for a while."

The provider did not keep a comprehensive record of the care people required and the care they had received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The interim manager and management team were aware that further work was needed to be carried out on people's care records to ensure that staff had the right information to support people. A system of 'resident of the day' was being embedded into the home which meant that the care, support and environmental needs of one person on each unit would be reviewed by all departments with the person every day. For example, the chef would visit the resident of the day to discuss their dietary preferences and needs to ensure they were receiving meals which provided them with a nutritionally balanced diet they would enjoy.

Systems were in place to help staff keep informed of changes in the management of people's needs and the running of the home such as detailed handover meetings. The clinical development nurse was reviewing the handover practice within each unit to provide a more structured handover which would reinforce the support needs of those with clinical risks and who required end of life care. Daily stand up meetings also occurred with representatives of all units and departments to keep staff up to date with people's needs and share any concerns.

Since being in post the interim manager had acted on relatives concerns about the reduced and fragmented communication from the previous management team to the relatives. They had set up regular meetings with people and their relatives as a group as well as individually. Most people and their relatives shared with us that they felt the communication in the home was improving as a result of the new management however others felt that further improvement was still required. One relative said they were confident in the new management team and said, "I'm very happy. I have no concerns. If I raise a problem, they always sort it out and I will always check that they do."

The interim manager explained that they had an 'open door' policy and welcomed the views of people and their relatives and said, "I know we have a lot of work to do with our relatives, to build up their trust and improve on how we have communicated with them in the past." The interim manager had reviewed some of the complaints which had been responded to by the previous manager to ensure that there was a satisfactory outcome and was continuing to work with some relatives who had outstanding and ongoing concerns. Relatives told us they had received initial assurances from the interim manager and provider representatives that action would be taken to address their concerns but were concerned that improvements were taking longer than anticipated.

We have asked the provider to keep us updated of the outcomes of their investigations and actions taken in response to people and relative's complaints to assure CQC of the effectiveness of the provider's complaints process.

Requires Improvement

Is the service well-led?

Our findings

The home had undergone some recent changes in the management of Badgeworth Court Care Centre. An interim manager, clinical development nurse and peripatetic manager had been deployed by the provider to manage the home until a permanent manager was recruited. They were being supported by the regional director and other representatives of the provider. The interim manager had been part of the quality team who had inspected the home at the beginning of July 2017 and understood the improvements that needed to be made. The provider's internal improvement plan highlighted similar areas for improvement to what we found at our inspection. This included improvements required in people's care records and quality monitoring systems, ensuring a stable staff team was recruited and that staff received sufficient professional development and support. The provider had started taking action to address these shortfalls for example, a peripatetic manager had started reviewing people's care plans and risk assessments.

There were some auditing systems in operation to check the quality and safety of the service people received, for example health and safety checks and housekeeping checks had been completed. Some improvements were already being made. The clinical development nurse described the action they were taking to improve medicine management in the home and the interim manager's improvement plan showed that progress had been made in for example, the correct use of codes on people's MARs. The interim manager told us they were aware that the provider's Internal Compliance Audits such as medicine and infection control audits had not been completed routinely and were planning to complete these in the coming week. They were also scrutinising all audits for accuracy. For example, when the housekeeping audit scored high the interim manager requested this be revisited before validating it as they felt it did not reflect the improvements that were needed. The interim manager or the senior staff member in charge did a comprehensive walk around daily to check on the actions being taken.

The provider had not ensured their nursing care monitoring systems were always used effectively to ensure people had received safe and appropriate nursing care. This had been identified by the provider as an area that required improvement and action was being taken to implement these systems. A clinical governance audit had been reintroduced and the first one was completed in August 2017. This ensured the service recorded who had clinical needs, for example pressure ulcers, any skin tears, catheter care or weight loss. This information was then sent to a member of the provider's clinical team. The interim manager was introducing regular clinical governance meetings where they would discuss those people with high clinical risks as well as review any accidents, incidents, falls and any medicine errors. The first clinical governance meeting was taking place on 23 August 2017.

Daily heads of department meetings were also taking place to discuss any concerns that need addressing each day. The provider was also introducing their pressure ulcer prevention programme called 'MI Skin matters' at Badgeworth Court Care Centre in conjunction with training the staff. This included documentation on checking the skin and using a measurement tool called 'The safety cross'. The interim manager was also working with commissioners and the local care home support team to drive improvements such as delivering some staff training in clinical subjects to ensure people's clinical risks were being managed appropriately.

We looked at the arrangements that had been put in place to reduce the impact and risk to people of the service shortfalls whilst the provider was completing their improvement plan. We found these were not always effective. For example, unit manager checks had been put in place to check people's topical medicine administration records (TMAR) daily. This was to ensure TMARs were completed when topical medicines were administered and action taken when omissions were found to ensure people received their creams as prescribed. However we found there were still gaps in people's TMARs, with no record whether these gaps had been identified and whether action had been taken to manage any resulting risks to people's skin.

Following concerns raised about people's nutritional intake the interim manager had monitored all people's nutritional intake for two weeks and identified those people at risk of not eating and drinking enough. They had instructed staff to continue monitoring these people's nutritional intake. However we found these records had not always been completed and the system that had been put in place to monitor nutritional risk was not effective in informing staff whether people were being supported to eat and drink enough.

The provider had deployed a clinical development nurse to support with monitoring people's nursing care till a clinical lead was in post. However we found scrutiny of people's care had not always taken place. For example, we found that three people had wound care plans in place but the quality of the recording was poor and we could not determine whether these wounds had healed or still required treatment. The clinical development nurse who was overseeing the nursing care, could not tell us how many people had pressure ulcers or wounds in the home. They told us they had not scrutinised people's wound plans or the wound care people had received and could not confirm whether people had received wound care in accordance with the provider's guidance. This placed people at risk of not receiving appropriate wound care till the provider's clinical governance systems were embedded in the home.

The provider had but systems in place to ensure people would receive personalised end of life care whilst improvements were made to staff training. This included requesting the GP to review people who might be at the end of their life and working with the Care Home Support Team, local hospice staff or the Community Palliative Care Team to ensure people would receive end of life care in accordance with current national best practice. However, as we noted in our Caring domain this multi- professional input had not always resulted in improved outcomes for people. When recommendations had been for example, by the Care Home Support Team to ensure that people's end of life wishes would be documented this had not been implemented and people were at risk of not receiving personalised end of life care.

Systems that had been put in place to mitigate the risks relating to the health, safety and welfare of service users had not always been operated effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the morale of some staff was low. Staff we spoke with felt they were under pressure and attributed this pressure to a high turnover of staff. Some staff also felt they worked tirelessly but felt this was not always recognised by management who they were still getting to know. There remained some anxiety about ensuring that the improvements made would continue and become embedded. One staff member told us, "There are so many changes, they say it is for the better but we will just have to wait and see''. Another staff member said, ''We have seen it all before, with another change in management coming I am a bit worried about whether the improvements will remain''. This concern was exacerbated by the fact that the interim home manager was to be replaced when a new home manager had been appointed.

The interim manager and provider recognised that the recent turnover of staff had been central to the morale of staff and effective management of people's care needs and the running of the home. They were

actively recruiting nursing, care and non-care staff and had recruited a deputy manager to support the management structure. Plans were also in place to recruit a clinical lead, who would be supported by the deputy manager to provide clinical support and advice to staff.

However some staff were feeling confident in the new management structure and the support they were providing. A catering staff member told us "Since the new manager came I am much clearer on what is expected of me". We found that some staff expressed concerns about the temporary nature of the management structure and the uncertainty of the home. When one staff member was asked about the new management and replied "The jury's still out. Things seem to be improving but there's a long way to go yet." This was recognised by the interim manager who had implemented a plan to improve the regularity of staff meetings, communication and staff development and support. We discussed our findings about the staff views with the interim manager and regional director who told us they frequently visited the home and felt the culture of home was slowly moving forward and had noticed a positive change in the atmosphere in the home and the staff spirits.

People and relatives also gave us mixed feedback about the management team and the changes that had taken place in the home. Some relatives told us they had lost trust in the previous manager and were cautious of the new temporary management team in post. They felt the home had 'some way to go' before they would be assured that their loved one would receive the care they needed. However other relatives said comments such as "It seems much cleaner lately and the new manager seems to know what she is doing" and "we have had some concerns lately about Mum. I spoke to the new manager and I can see things are improving for the better. I am pleased."

Since being in post the new managers of the home had started an engagement programme of relatives/resident meetings which had allowed people and their relatives an opportunity to express their views and be updated about changes in the home. Records showed a 'resident and relatives' meeting had been held on 17 July 2017 during which concerns had been raised about the cleanliness of the home, the food and activities. We saw the manager had address these concerns with the relevant staff on 19 July 2017 and plans were being implemented to make the required improvements. Relatives of the home were also in the process of forming a committee to give them a forum to discuss issues which may have impacted on the well-being of their family member. The interim manager had been invited to attend the committee meeting and said "This is a huge step for us in the development and progression of building our relationships with our families."

A business continuity plan was in place which guided staff with the actions they should take in an emergency situations or a major incident such as flooding, fire or outbreak of an infectious disease, although it did not accurately reflect the staff responsible for co-ordination of the emergency arrangements.

The provider was displaying their previous inspection rating in the home and on their website as required by law.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care and treatment appropriate to their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems that had been put in place to mitigate the risks relating to the health, safety and welfare of service users had not always been operated effectively. The provider did not keep a comprehensive record of the care people required and the care they had received and the decisions taken in relation to people's consent to their care and treatment.