Barchester Healthcare Homes Limited

Park View

Inspection report

1-2 Morland Road
Dagenham
Essex
RM10 9HW

Tel: 02085937755
Website: www.barchester.com

Date of inspection visit:
18 July 2018
19 July 2018

Date of publication:
31 August 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 18 and 19 July 2018. Park View is a care home providing accommodation and nursing care for 108 adults including younger adults who may have a diagnosis of dementia. At the time of our inspection 108 people were living in the service.

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

The service did not have a registered manager in post. At the time of the inspection there had not been a registered manager in post for 100 days. 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.

At our last inspection on 18, 19, 21 and 28 July 2017, the service was rated 'Requires Improvement'. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always have plans in place for managing risks people faced. The provider did not always manage and administer medicines safely, and guidance for how to administer medicines covertly was not always clear and some decision forms were incomplete. There was not enough suitably qualified, competent, skilled and experienced staff in place to meet the requirements of people using the service. The provider did not ensure staff received appropriate support, training, professional development and supervision necessary to enable them to carry out their duties. Quality assurance systems and audits had not operated to assess and improve the quality and safety of the service provided.

At this inspection we found that these breaches had been addressed.

People using the service and their relatives said the service provided safe care and treatment. The service managed medicines safely. However, not all 'decision to administer' forms were updated to match people's changing prescriptions and not all medicines were disposed of appropriately. The acting manager addressed these concerns following the inspection. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. People were protected by the prevention and control of infection. There were robust procedures in place to protect people from harm and staff were clear on how to recognise and report abuse. The provider assessed and managed risks to people in a way that considered their individual needs.

Staff understood the Mental Capacity Act 2005 (MCA). MCA is law protecting people who are unable to make decisions for themselves and where people were not able to do this, the appropriate authorisation procedures had been completed. These are referred to as the Deprivation of Liberty Safeguards (DoLS).

Staff undertook training and received regular supervision to help support them to provide effective care. People were encouraged to live a healthy lifestyle and received holistic support from various health and social care professionals.

People and their relatives told us staff supported them or their relative with dignity and respect. They ensured people's privacy was maintained particularly when being supported with their personal care needs. People were supported to be as independent as possible and staff supported them in the least restrictive way possible. People and their relatives felt involved in the running of the service and could have an input into the care provided.

Each person had an individual care plan. However, these care plans were not always up to date and did not always reflect people's support needs. The acting manager advised the care plans were being reviewed. The service did not always have enough meaningful activities in place to ensure people were engaged. The acting manager advised they were addressing this. People and their relatives felt comfortable raising any issues they might have about the service and there were arrangements in place to deal with people's complaints. The service supported people with their end of life wishes.

The service and provider demonstrated an open and transparent culture. They routinely gathered feedback from people, relatives and staff. This feedback alongside the acting manager's audits and quality checks were used to continually assess, monitor and improve the safety and quality of the service. Staff felt valued and supported by the acting manager who was approachable and knowledgeable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely. However not all 'decision to administer' forms had been updated to reflect people's changing prescriptions.

Staffing levels were appropriate and staff had been recruited in a safe manner to ensure people in the home were safe from harm.

Staff were aware of safeguarding procedures and knew how to identify and report abuse.

Risk assessments were in place and ensured risks to people were managed and people were safe.

There were systems in place to reduce the spread of infection.

The service monitored all accidents and incidents and learnt lessons to prevent future instances of people being at risk of harm.

Is the service effective?

Good

The service was effective.

MCA assessments had been carried out to check if people had capacity to make certain decisions. The acting manager and staff were aware of the principles of the MCA and supported people in line with their best interests.

Staff had the knowledge, training and skills to care for people effectively.

Staff received supervisions and felt supported in their role.

People's needs and choices were assessed to deliver personalised and effective support.

People were encouraged to live a healthy lifestyle and were in touch with health and social care professionals to keep them well.

Is the service caring?

Good

The service was caring.

Staff understood the principles around equality and diversity and ensured all people felt comfortable and supported.

People received support from staff that was caring and person-centred.

People and relatives were involved in decisions about the care and support they received.

People's privacy and dignity was respected.

People were encouraged and supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always updated to reflect people's changing support needs. They did not always include information on how to support people.

Staff did not always have a good understanding of people's support needs.

The service did not always provide enough meaningful activities for people.

The service supported people at the end of their life to be comfortable and took into consideration their wishes.

The service responded to all complaints and people were confident with raising concerns.

Is the service well-led?

Good

The service was well-led.

Quality assurance systems were in place for continuous improvements to be made.

Staff were positive about the acting manager and felt the service was well-led.

People and their relatives could provide feedback about the

service and this was being acted upon to develop the service.

Park View

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.

We carried out an inspection of Park View on 18 and 19 July 2018. This inspection was unannounced and carried out by two inspectors, one pharmacist specialist and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed relevant information that we held about the service. This included the previous inspection report, and notifications we had received. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We contacted other health and social care professionals for their feedback, including Healthwatch. The Local Authority, who have a commissioning role, sent us a copy of their most recent quality assurance monitoring report. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke to 20 people who used the service and seven relatives. We spoke to 15 staff members, including the acting manager, the regional manager, the chef, the activities co-ordinator, an administrator and care staff. We also spoke to three health and social care professionals. We reviewed documents and records that related to people's care and the management of the service, including 15 care plans, 15 staff files, the staff rota, Medicine Administration Records (MAR), service audits and health and safety policies and procedures and records.

We also undertook general observations of people in each community and 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.

After the inspection we received further documents including the resident's handbook and an action plan addressing the recommendations we made during this inspection.

Good

Is the service safe?

Our findings

People using the service, their relatives and healthcare professionals told us the service provided safe care. One person said, "I feel safe [at the service]. Staff are polite." A relative said, "Yes, [my relative] is safe. I have not noticed anything to worry me that [my relative] is unsafe."

At our last inspection in July 2017 we found that medicines were not always managed and administered safely. During this inspection we found people felt safe with receiving their medicines. One person said, "The nurse gives it to me and they wait [for me to finish]. I have no complaints," and another person said, "The nurse puts [my medicines] in my hand one at a time."

There was guidance on how to manage covert medicines and people receiving medicines in this way had 'decision to administer' forms in place. However, the 'decision to administer' forms did not always match the person's prescription on their Medicine Administration Records (MAR) as changes to the patients' prescription did not trigger a review of the form. We raised this with the acting manager during the inspection. Following the inspection, the acting manager advised that all people receiving medicines covertly were to be reviewed to ensure that the covert medicines they were prescribed were still applicable to their needs. We were further advised that once this process had been completed, all 'decision to administer' forms would be reviewed to reflect prescribed medicines.

Controlled drugs are medicines which are more liable to be misused and therefore need close monitoring. We found that these were stored and managed appropriately.
We saw medicines returns were not appropriately documented. We raised this with the acting manager during the inspection and were informed that the contracted company had not collected for some time, despite being contacted. They were collected during the inspection following further contact. After the inspection, the acting manager advised that the pharmacy had been contacted to request that as soon as they received notification medicines should be collected.

Some people were prescribed medicines to be given only when needed, known as PRN medicines. We saw that there were administration protocols in place. We also saw on MAR that people were regularly offered their PRN medicines.

We looked at MAR on all the units within the service and observed a medicines administration round in one unit. Medicines were administered safely, there were no gaps on MAR and medicines stock obtained from the pharmacy could be matched with the administration records. We saw that medicines were stored securely in appropriate medicines cupboards. Room and fridge temperature were monitored daily to ensure that medicines remained suitable for use. There was evidence that people receiving medicines that needed regular blood monitoring and dose changes were appropriately managed. We saw records of people whose medicines had been reviewed by the GP.

Records showed that staff had undergone medicines training and had completed their competency assessment. Staff told us that medicines audits were done monthly. We looked at audit results for the

previous three months and found findings were acted on and signed off by the acting manager.

At our last inspection in July 2017 we found that the provider did not have sufficient numbers of staff to meet the requirements of people using the service. At this inspection we found there were enough staff to meet people's needs. People, relatives and staff told us they felt there were enough staff at the service. One person using the service said, "You have got to ask for somebody and they are there. There are enough staff." A relative told us that there were enough, "Polite and experienced" staff to support people. One relative spoke of staff being, "There in minutes," and another told us, "There is enough. Whenever I have looked for staff there is always someone."

One person told us, "Sometimes if you need them they say they are busy and have to help other people." However, this person told us they felt safe and staff would always come to them. A relative told us the community where their relative lived was, "Understaffed". We discussed this with staff and reviewed the support arrangements for the person and found staff were available to meet the person's needs. The relative of the person felt that the person was not at risk. Staff we spoke with told us they were not rushed and they felt there were sufficient number of staff to care for people. One staff member said, "Yeah definitely" when asked if they felt there were enough staff.

The acting manager explained the current staffing arrangement, which included different numbers of staff on each unit. We noted that based on some people's assessment of needs they were allocated one-to-one staff support. We reviewed the staff rota and noted that each unit had sufficient number of staff during the day and night shifts to meet the assessed needs. We were informed that the staff levels changed based on the needs of people using the service. The acting manager told us the service had bank staff who could cover any sick leave or unplanned absence. The acting manager advised recruitment for permanent staff was ongoing, and an additional three full time nurses had recently been recruited.

We looked at staff recruitment records and found the provider had completed appropriate employment checks before they began working for the service. These included completion of application forms by staff, checking of any gaps in employment, references from previous employers, proof of the person's identity and right to work in the United Kingdom and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that provides
information about criminal records. Staff we spoke with confirmed the provider had completed the checks before they started to work with people using the service.

The provider had safeguarding procedures in place to protect people from abuse. The acting manager told us, and staff and records confirmed, that staff had read these procedures. The procedures included clear guidance for staff on what to do if they had any concerns and who to contact. Training records showed that all staff had completed safeguarding training. Staff knew what to do to protect people from harm. One staff member said, "Abuse is really serious. You make sure you do the right thing." Staff could list examples of abuse including physical, emotional, financial and sexual. Staff described the actions they would take if they thought a person was abused. One staff member told us, "I would report it to my acting manager. If I thought nothing was being done, I would whistleblow. I would also make sure the person is safe." Another member of staff said, "I would tell my acting manager and if nothing was done I would report it to CQC, or local authority or the police. I am aware of the whistleblowing policy."

Each person had their own risk assessments. These identified potential risks to people and provided guidance for staff on how to ensure they were safe. Risks identified included choking, epilepsy, falls and the development and management of pressure ulcers. Staff had a good understanding of how to manage the risks people faced. For example, one staff member told us, "[Person] is on puree, and may choke. When we

feed [person] we make sure [person] is upright. When feeding [person] I take time, wait for [person] to swallow before the next spoon." One person's risk assessment stated, "[Person] is unable to use call bell system", and advised staff, "To do hourly checks." Records confirmed this person was receiving hourly checks. Risk assessments were reviewed monthly or more frequently, when needed.

We saw the provider had completed environmental risk assessments including fire safety, use of equipment and hazardous substances. Records showed that regular checks of fire alarms, fire doors and emergency lights were undertaken and equipment and facilities maintenance was carried out to ensure they were safe. The service carried out routine fire drills. Each person using the service had a personal emergency evacuation plan (PEEP) in case of a fire. Two maintenance staff checked, recorded and reported various aspects of safety within the service. The maintenance files confirmed risks were all appropriately recorded.

People, relatives and visitors told us the service was clean and tidy. One person said, "The home is always clean." Another person told us, "Every day they clean the place. They use a special hoover." A relative told us they came to the service regularly and they found it was, "Always clean". Another relative said, "It never smells, there is always a cleaner here."

We found all communal areas were clean and free from offensive smells. We saw staff cleaning corridors, communal areas and bedrooms. We saw the kitchen was clean and all measures were in place to ensure food was prepared safely. All kitchen equipment had been tested. The temperature of the fridge was monitored daily. We saw staff wearing personal protective equipment such as gloves and aprons and noted that the provider had an infection control system in place. Hand gels were available throughout the service and dirty clothes were transported to the laundry room in marked baskets. The laundry assistants were clear how to separate and wash various kinds of clothes including soiled ones at the recommended temperatures. The service recently received a five-star rating for food hygiene. The acting manager worked as the infection control lead to check necessary materials were available and staff followed the service's infection control system.

The service had systems in place to record and learn lessons from accidents and incidents. One staff member told us, "We have an accident and incident book. The nurse gives the form to the [acting] manager and they make decisions." When we asked staff how they would know of any accidents or incidents that had occurred while they were away, one staff member said, "My colleagues tell me what has happened, also I read the accident and incident book." The acting manager gave us examples of how they had made changes to the service because of incidents. For example, they told us and records confirmed, "[One person] had twelve incidents and accidents between January and June last year. The number of incidents and accidents over the same period this year had reduced to six." This was related to a person displaying behaviour that challenged. The service organised a review with the person's GP, psychiatrist and family. The service ensured there was a consistency in staff who supported this person. They told us all incidents and accidents were recorded, analysed and reported to senior management. The registered acting manager also reviewed and made comments on the incidents for staff to ensure people were safe. This demonstrated that the service could learn lessons and make improvements when things went wrong.

Good

Is the service effective?

Our findings

People and relatives told us that staff were skilled, knowledgeable and able to provide care and support. One person told us, "They are trying." A relative said the staff are, "Very helpful, they help with everything." Staff demonstrated they knew how deliver effective care and meet people's needs.

At our last inspection in July 2017 we found that staff did not always understand the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection we found the service was working within the principles of the MCA and records confirmed that all DoLS had been applied for. One person spoke to us about a knife they used to own, and said it was not with them at this service. They said, "I understand if I had a turn I could hurt someone. My daughter keeps it at my house, it is still mine. It's fair enough." This shows the service was supporting people to make their own decisions as far as possible in line with what was best for them and others.

One staff member told us, "You have to let the person make a decision for themselves, give them a chance." Another staff member said, "If you have to make a decision for them make sure the decision is best for them, not what is best for you." They told us of one person who was diabetic and liked to eat cake, but it could have too much sugar and make them unwell so they, "Explain this to them and help them buy a cake with less sugar, at least then [person] is happy but it is good for them." During the inspection staff were observed to get consent from people before doing anything for them. We saw staff knock before entering people's room. One staff member told us, "I will knock when their door is shut. Even if it is open I knock to check they are okay."

We saw that information was available within the service for people and staff about the MCA. One staff member told us, "[Acting manager] gave everyone a bite size revision card, we know the five principles. We should always assume everyone has capacity. I look at this card regularly."

One person's care plan said, "It was decided that it is in [person's] best interest to close the water tap in bedroom to stop [person] from drinking water without thickener and therefore reducing the risk of aspiration pneumonia. I am liaising with the DoLS department to include these restrictions in [person's] DoLS assessment." This person had one to one support in place during the day, and their bedroom tap had been turned off. This demonstrated that the service was following the principles of the MCA.

At our last inspection in July 2017 we found that the provider did not always provide on-going training to staff to enable them to fulfil the requirements of their professional role. During the inspection we saw that

staff received sufficient training to allow them to provide high quality support to people.

One staff member told us, "We have a lot of training. I know it but it's always good to refresh." Another member of staff said, "Training is really good." Records showed that staff members received training that was required for them to perform their roles effectively and in accordance with the Care Certificate standards. The Care Certificate is a set of standards that health and social care workers stick to in their daily working life. Training covered health and safety, infection control, safeguarding, MCA and DoLS, equality and diversity and moving and handling. We spoke with the training co-ordinator who gave details on what training staff attended. They advised training was flexible based on staff needs. For example, during the inspection staff were completing training on moving and handling. Staff had identified they had more difficulties with chair work so they focussed more on this area. The training co-ordinator told us, "Attendance has improved, it's been brilliant, people are enthusiastic and they are proactive rather than reactive, they ask for training more, this comes from management." They also confirmed, "I feedback to [acting manager] before I leave."

The acting manager advised that all staff were reminded of what training was mandatory and the importance of attending. When we asked the acting manager how they knew the training had been effective, they said all senior staff are, "To be visible and on the floor to monitor the effectiveness of training, and trainers report back to acting manager." For staff who had completed their training days but might have felt they needed more support on a topic, the acting manager told us, "We have tablets for them to do e-learning." This meant staff could access e-learning at work, and refresh their knowledge.

This demonstrated that the acting manager always knew about any gaps in learning identified during training and could then put a plan in place to manage this. This ensured that all staff were adequately trained to be able to provide effective care and support to people.

At our last inspection in July 2017 we found that staff did not always receive appropriate support through supervision meetings. During this inspection we found that staff received more regular supervisions which enabled them to feel supported and equipped them with the tools to carry out their role. One staff member told us, "We get regular supervisions." Another staff member said, "We now make sure everyone is doing their training and supervisions." The acting manager advised they have an, "Open door policy," and makes a more pro-active effort to listen to staff and support them with their concerns.

Records confirmed supervisions were taking place. However, we found that there were multiple templates used for different types of supervisions. It wasn't always clear what the reasoning behind using a different supervision template was. We discussed the importance of clarity and fairness with the acting manager to ensure all staff were receiving the appropriate level of support. Following the inspection, the acting manager advised they had agreed on one template to be used moving forward.

Staff received a detailed induction before starting their job. One staff member told us about their induction and said, "I had training at the beginning in fire safety, dementia, how to use the equipment, safe ways to move the residents and how to lock away dangerous liquids. I found it helpful." Another staff member said, "Yes it helped. It helped a lot, we looked at how we give personal care. I learnt how to use the hoist and other equipment." Records show that inductions covered communication, confidentiality and record keeping, person centred support, medicines, safeguarding, health and safety, dementia care, equality and diversity and distress reaction training. New staff would shadow more experienced staff during their induction and received more regular supervisions. Their performance was reviewed at 6 and 12 weeks before being signed off as competent to work independently.

The service completed pre-admission assessments to ensure that they could offer the best support to the person. These identified people's support needs and risks. They included information about peoples likes, dislikes, medicines, allergies and communication needs as well as their social and spiritual values. For example, one pre-admission assessment said, "[Person] would like two pillows and likes cats and fish, EastEnders and Holby City."

People were given a choice about whether they wanted personalised signs on their bedroom doors to help them locate their bedroom and feel more at home. People told us they could decorate their rooms in any way that they wanted. One person said, "I could choose what colour I want and they would do it." We were told one person liked the colour purple and saw that their bedroom had been decorated in purple. A relative told us, "My mum calls it her room now." Records show that during resident meetings, people were asked how their room was. One person said they liked it and it was comfortable for them. Private lounges were available for people and their visitors. Relatives told us there was always space to meet and spend time with their loved ones.

People and relatives told us the food was good. One person said, "I like the food. It's enough." Another person told us, "I always have a good breakfast in the morning." One relative said, "It's okay. [Person] will have a cooked meal and they ask [person] what they want."

We looked to ensure people were being supported to keep hydrated. One person told us, "They always offer you a drink." Another person said, "I get a mug of tea any time I want." One staff member said the acting manager was, "Always pushing water, makes sure everyone has a drink." Fresh water and refreshments were available on each community for people to access at any time. We also saw that trolleys went around each community during the day, in-between people having their meals. Staff advised that at any other point people could ask for more food and drinks of their choice. The acting manager told us that each person had a fluid booklet in their room, to remind staff and encourage people to keep hydrated. This was confirmed during observations.

In the kitchen there were details of people who had specific allergies, people who needed additional supplements in their food and what people's individual preferences were. The regular chef was away at the time of the inspection. We spoke to the interim chef who knew about individual likes and dislikes. They told us one person liked their food in a Chinese takeaway box each day, and another person liked more vegetables than meat on their plate. They also said five people were going to a Caribbean restaurant. The following day we saw photographs of this event and one person told us, "It was excellent." We saw that people's cultural and religious needs were considered when preparing their food. This shows that the service provided a varied and healthy diet based on people's individual support needs.

People and relatives told us that they received care and support from various health and social care professionals. One person said, "If I had an ulcer I would ask. They would get a doctor if I needed. I had an injection, a professional came in." Another person told us, "I went to the dentist for false teeth." One relative told us, "If they aren't well then straight away they get an ambulance or get help, I can't find fault at all." Another relative told us, "The have a chiropodist, a hairdresser, an optician." One staff member said, "Social workers ask us how so and so are doing. Just now I was telling [person's] social worker how they are doing." Records confirm that the service was pro-active in reviewing people's care and support needs. One person's file had a letter from the memory services that said, "We have received a referral from Parkview…concerns around recent deterioration."

People were supported to keep healthy and well. One person told us they, "Go to the gym in the hospital." One staff member told us, "[Person] likes smoking every hour. We try and make this every two hours as it's

not healthy but if [person] wants it hourly it is their choice." During our inspection we observed one senior staff member inform their team they were in the process of organising an assessment to review a person's needs and this person's family and the social worker had been invited. This showed that the service worked well together as a team and with other organisations to provide effective and holistic care and support for people to enable them to live healthier lives.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person said, "[Staff] are fantastic and kind." Another person told us, "They listen to me. They do a morning call to see if you are alive. If you are not up for a cup of tea in an hour they want to know why. They like to see my photographs. In general, the care is excellent." A relative told us the staff were, "Very nice people, I trust them." Throughout the inspection staff were observed to have caring relationships with people and demonstrated a kind and compassionate approach. Staff were seen to be touching the arms of people in a gentle manner and asking how they were.

Each community had a 'resident' of the day. The 'resident of the day' was involved in more person-centred activities. Staff gave examples of people having a day out to somewhere of their choice, or a longer one to one session with the activities co-ordinator. Staff said this helped people feel special and supported. Relatives of people who had been chosen as 'resident of the day' were informed and asked to be involved in any way they wished. One relative said, "Staff take a real active interest in trying to find out about [person] and ask me for my thoughts. [Person's] life has improved since being here, personal hygiene has improved, [person] eats more and is communicated with better."

Staff completed training on equality and diversity and demonstrated a clear understanding of what this meant. The training co-ordinator advised within equality and diversity training they look at the nine protected characteristics and staff discussed how they would welcome people to the home who identified as LGBT. One staff member told us, "[Staff] speak every day to make sure everyone has the same rights as each other, regardless of their cultural background," and they felt equality and diversity was always discussed in the home. This demonstrated that the service worked in an inclusive and respectful manner. Furthermore, the acting manager showed us a LGBT folder that was in the process of being developed for staff to refer to. This folder contained CQC and other best practice guidelines.

Staff gave examples of how they listened to what people wanted and helped them get it. We met one person who loved to read the newspaper and said, "[Staff] gets me one every day." One staff member who worked in the administration team told us they purchased the newspaper when they went to the bank. They also told us they asked people who are able if they want to come to the bank with them. They said, "They come with me to the bank, we go for a walk, why not?" We met one person who was not currently entitled to public funds which meant they did not have any money to purchase items for themselves. One staff member told us, "I give her all my clothes, we are a similar size, she loves it, it makes her happy." This showed that people were treated with kindness and support was available for them when they needed it.

Records showed that there were two types of monthly resident meetings. For people who were unable to get out of their room, staff would ask them questions about the support they received and gather feedback. Notes showed, "I asked [person] permission before asking questions." There were also larger resident meetings that took place in the communal areas. One person was recorded to have said, when asked if they felt they could express their views to staff, "Oh yea, yea, talk to 'em like they're me sisters." One relative told us, "They write everything down." This demonstrated a caring and person-centred approach and ensured all people could actively express their views.

The acting manager told us the service involved family and friends of people as much as possible in the shaping of the care provided. Relatives told us the service contacted them and told them how people had been feeling, what they had been up to and if there were any upcoming plans or day trips. One relative told us, "They ring us," to tell them of any changes or updates.

People told us they felt staff respected their privacy and dignity. One person told us, "The ladies who work here are very good. I had a body wash. They did it perfectly. Couldn't fault [staff]." One relative told us, "[Person] doesn't like them touching but they are very gentle. They know [person]. They respect [person]. They know what [person] is like." We observed that staff would shut people's bedroom doors when delivering personal care or wait outside the bathroom for people if they needed support. This demonstrated staff worked in a manner that respected people's privacy.

The service encouraged people to be as independent as possible. One person said, "It's so good. I don't like mashed potato. I like [traditional food reflective of person's culture]. I make it myself in the small kitchen." A relative told us, "Before [person] wouldn't participate but the activity woman is getting to know [person] and now [person] is down here all day." Another relative said, "We can take [person] out whenever we want. We tell them what time we are going out, what time coming back, so they monitor [person's] safety." The activities co-ordinator spoke positively of many people who had become more confident and independent since engaging with activities. They said, "I ask them to help prepare and get involved with things too. People love to help. We get people involved as much as they can." They told us specifically of a person who used to say they couldn't use their hands and would only watch and now they are much more engaged and confident.

Staff could give clear examples of how people communicated and how they encouraged people to manage their own personal care and when they knew to help. One staff member told us, "[Person] likes to be independent. Ask [person] if they'd like a shower now or later, [person] usually likes after breakfast. [Person] eats in their room and then presses the buzzer and we support [person]. When [person] is in the shower they tell us we can stand outside and they'll let us know when they have finished." Another staff member said, "I let people choose what they want to wear that day, or how they want their hair." This demonstrated staff supported people to be as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

Each person had their own care plan. Care plans contained a large amount of information including what their support needs were around communication, personal hygiene, sleeping, cultural values, hopes and concerns for the future and what they wanted their daily routine to look like. One person's communication care plan said staff were to, "Speak clear and loud, give clear instructions before doing any care procedure. [Person] is able to express likes and dislikes, give [person] time to explain, staff to offer choices." Another person's plan around personal hygiene said, "[Person] likes to have hair very short."

However, not all care plans had been updated to reflect people's changing support needs. For example, one person had a communication plan in place, but the daily records were about the person's blood pressure. These two support needs were not related and it was therefore unclear how the person was progressing with their communication or what support they needed with their blood pressure. Furthermore, care plans were not all ordered in the same format and some information was duplicated but differing slightly in its detail. For example, one person's care plan had a healthcare professional record at the back of their file that was empty but throughout the plan there was evidence of healthcare professionals reviewing the person's care and support needs. Another person's care plan had key contacts that differed in detail throughout the file.

One staff member was on one to one observations for a person, and told us, "[Person] has thickener in water." They knew they needed this as they were at risk of choking but they were not able to tell us why they were at risk of choking. Another staff member told us this person was at risk of choking because of a historic stroke. This information was recorded in the person's care plan.

This confirmed that care plans were not easy to follow and did not paint a clear picture of a person and their individual support needs. Therefore, staff would not always know accurate details about a person and what support to offer them.

We spoke with the acting manager who advised they had identified this issue and showed us their action plan. They understood that care plans needed to be updated and needed to be more person-centred. The acting manager had ordered new files that had a more relevant and full index. This would allow for records about people to be better organised and easier to access and review. We were also advised that senior staff were to complete 'document refresher training' in August 2018 and all records for people would be reviewed by April 2019. The acting manager advised the service would prioritise reviewing those with the most pressing support needs. This would ensure all staff, regardless of how long they had worked for the service, would be able to read a person's file and fully understand their care and support needs.

The decision made by management as to what community people should move to was not evidenced in people's care plans. When speaking to staff during the inspection it wasn't always clear what the difference between each community was, and how people had been assessed to be suitable for a community. This meant the service was not always providing care that responded to people's changing needs. We spoke with the acting manager about this. After the inspection they sent us a description of each of the five

communities and told us this had been shared with staff. They also advised that moving forward, they would clearly record how a decision had been made that led to someone being in a community and as part of care plan reviews they would look at what community would be best for the person. This would ensure that people were living in a community that could provide them with the best care and support.

People and relatives told us that the service offered opportunities for people to engage in a range of activities that suited their needs. One person told us, "There are quite a lot of things to do. Tap dancing and they bring animals here like snakes. They photograph what we are doing." Another person said, "We go out on a bus and take a packed lunch." Relatives told us the activities were good. One relative said, "They read to [person], or put on music, they know what [person] likes."
The service had two activities co-ordinators. One told us they focussed on spending time with people who were unable to participate in group activities either because of their health needs or if they were more isolated than others. They visited people in their bedrooms and had one to one time with them. Activities included reading, hand massages and manicures, tea and a chat and card games. We observed this staff member reading to a person in their room, who was unable to read themselves. Staff told us this person likes classical music, so they were reading them a short story about a pianist. The person was smiling.

The other activities co-ordinator oversaw group activities. These included music therapy, arts and crafts, board games, cake decorating, bingo and film afternoons. We saw there was a queue for the hairdressing service and people sitting in the salon were smiling and laughing amongst each other. We observed the activities co-ordinator supporting one person to decorate stones to be sold at the upcoming summer fete. Relatives confirmed that, "They have fetes, singers, they make things." We also observed people in another community participate in a ball game. During the inspection one person told us they, "Love to play jazz, I would play it for anyone. I have 70 cd's, I listen to jazz all day long." We later saw this person with their cd's and told us they had a lovely morning, "Listening to jazz." We observed staff and people playing the 'Getting to know me board game' identified as a tool used to enhance the wellbeing of residents with dementia. This game allowed staff to capture information for people's life story books. People were observed to be smiling and laughing during the game.

Most staff felt there were enough activities to meet the needs of people. One staff member said, "We have a lady and lots to do." Another staff member told us, "Activities are upstairs and if people can't get there we do stuff outdoors or in the other lounges. The activities co-ordinator looks at this." We also met with staff from the maintenance team who supported the activities co-ordinators. They told us, "We always try and cater for people's individual cultural needs. We take [person] out to a Chinese restaurant, [person] loves it and gets to eat what they choose." They said, "In restaurants we ask if they have any photos so people can always understand what it will look like. We give them lots of choice." This shows that staff were offering person centred care that was responsive to people's personal preferences.

Each community had their own garden area. One person said, "I do go to the garden." Another person told us, "We go out when it is really hot. Had a barbecue the other day." During the inspection we observed people spending time in the garden. The service had its own cat. During the inspection we saw one resident interacting with the cat and smiling. One person showed us a photograph of them with a donkey. They were smiling and told us they liked that. We saw photographs of other events where animals had been bought into the home. People were seen to be laughing and petting the animals. Staff told us, "They love the animals." This created a homely environment and provided people with a sense of purpose and happiness.

However, during observations we noticed that on occasions people were not engaged in meaningful activities and were seen dozing in their chairs. One person said, "I sit on a chair for two to three hours. Sometimes I go to lounge." One staff member told us they would like to have another person support with

activities. Following the inspection, the acting manager advised they had successfully recruited an additional activities co-ordinator. This third activities co-ordinator would ensure that people had more access to meaningful activities.

Where appropriate, people had end of life care plans in place. We met one person who was receiving end of life care. They told us, "The staff respect me, they are trying." During the inspection we saw that one person's bedroom was dark. Staff told us, "[Person] is receiving palliative care. Wants lights off and curtains closed as it's too hot." Another staff member told us, "[Person] is at end of life, taking medication. We are doing re-positioning every hour, [person] is taking pureed food, soft meals and [person's] wife visits every day." Records showed that people were consulted about their wishes and relatives were involved in this process. One person's plan said, "[Person] has no fear of death and when time is here [person] would like family with him." Records confirmed this had been reviewed with the person's son and there was a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) form in place. This showed the service were providing personalised and responsive care to support people receive comfortable end of life treatment.

People told us they knew how to raise a complaint if they wanted to. One person said, "I would never complain [but] I would know how, I would tell the [acting] manager." Another person told us, "I would if I had to. I would tell the nurse." One person told us they complained about their wheelchair as it wasn't suitable for them, "Then someone came to assess and get me a new one." We spoke with relatives who told us they knew what to do if they wanted to raise a complaint. One staff member said, "We have a resident meeting once a month, they say their wishes and complaints and it is all documented." Records confirmed that all complaints had been acknowledged, investigated and responded to. The service also kept a record of compliments. One record said, "The prompt action by your night shift staff enabled us to arrive at the hospital to be with [person] when they passed." This showed the service were responsive to dealing with complaints to ensure a positive running of the service, and allowed people to feel safe and comfortable to speak up.

Good

Is the service well-led?

Our findings

At the time of this inspection the service did not have a registered manager in place. There was an acting manager who was going through the registration processes with the CQC. At the time of our inspection, the acting manager had been in place approximately 4 months. Following the inspection, we received a notification that the acting manager was now a registered manager.

At our last inspection in July 2017 we found that quality assurance systems in place to identify areas of improvement were not always used effectively. We found there were gaps in the audits, and action plans generated from findings of audits did not always include details of when actions were completed.

At this inspection we saw audits of records for people's care plans and risk assessments. However, these records were not being reviewed monthly although the service's policy stated this was how often records should be audited. We spoke with the acting manager who advised they had identified this issue and moving forward all records would be reviewed monthly. This would be overseen by the acting manager and senior staff.

We found that the service had clear systems in place to audit the overall running and development of the service. Records confirmed that the acting manager and the senior staff team completed unannounced visits to the service, night checks and daily community checks. These checks looked at staffing levels, health and safety, medicines management, the completion of paperwork and the quality of care and wellbeing of people in each community.

At provider level feedback was gathered via annual surveys. Information provided by relatives was collected centrally and data was then passed down to the service. Records confirmed surveys had been sent out for this year. Staff showed us a provider mobile phone app that they were encouraged to download. This app allowed staff to complete employee surveys and access information including additional training documents and access to the providers whistleblowing helpline.

People and relatives spoke positively of the acting manager and the service overall. One person said, "The acting manager checks on me and sees if I am okay." Another person told us, "This is like my second home. I have been here for 10 years. My friends…say you are living in a hotel." One relative said, "[Acting manager] is a good manager, in the last couple of months they have done a lot." Another relative said, "I can't fault anything. We looked around at other homes and it is quite eye opening how amazing this place is." This demonstrated there was a positive sense leadership at the service. Staff told us they could go to, "Anybody in management, not just [acting manager]." We observed the regional manager talking to a relative of a person, when the acting manager was in a meeting.

Relatives confirmed they felt involved in the shaping of the service. One relative said, "If there are any problems they phone me and when I arrive they tell me everything that is going on." Relatives were given opportunities to provide feedback about the service through surveys and meetings. Relatives told us they could speak with the management team at any time and didn't have to wait to raise any concerns or ask

questions.

Records confirmed that resident and family meetings were being held. The acting manager had implemented monthly surgeries for relatives who wanted to make an appointment to speak to management more formally, or if they were unable to drop-in. The acting manager advised these had been successful. The acting manager advised that they were in the process of implementing newsletters to be sent to relatives of people to inform them of what activities or events had taken place and if there was any news.

The acting manager had introduced "stand up meetings" which took place every day. One staff member told us, "The stand-up meetings are definitely for the better." During this meeting all senior staff met and discussed updates from the different communities and anything related to the overall service. We attended this meeting as part of our inspection and observed senior staff discuss new admissions, staffing levels, the weekly action plan, training updates and upcoming social events.
Staff told us they felt supported by the acting manager and enjoyed working for the service. One staff member said, "[Acting manager] doesn't sit in office all the time, [acting manager] asks how we are, I like that." Another staff member said, "It is marvellous working here. Staff are taken care of as well as the residents. [Acting manager] makes sure everything is going smoothly." During the inspection members of staff told us that they had previously left the service but had come back to work when they found out the new acting manager would be in place. One staff member said, "The changes [acting manager] has implemented have been incredible. Every morning [acting manager] walks down and does a unit check, checks in on everyone and makes the effort to get to know everyone."

The acting manager told us they were supported by their manager with overseeing the development of the service and offering support and guidance. The acting manager said, "I am really happy with this help." When we spoke with the regional manager about this, they confirmed they were supporting the new acting manager as they wanted them to feel mentored and supported all the way. During the inspection the regional manager was present throughout.

This showed that staff respected and valued the acting manager and that the service was well-led at all levels which in turn allowed staff to provide a high quality of care to people.