Rowans Care Homes Limited

Burton, Bridge and Trent Court Care Centre

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place over three days from the 8 to the 10 October 2014.

At our last inspection compliance actions were issued as the provider was breaching legal requirements, as we identified that improvements were needed regarding; mental capacity assessments, people's individual needs not being catered for in a timely way, people's nutritional needs and preferences not being met effectively, medication management and records, quality monitoring systems not being effective and inconsistencies in records. The provider sent us an action plan on the 18 July 2014 detailing the actions they would put in place to meet the relevant requirements by 30 Sept 2014. We found that although some improvements were seen at this inspection further improvements were needed.

One compliance action issued following our visit on 13 January 2014 about the premises was also followed up at this visit. This related to people not being protected

Summary of findings

against the risks associated with unsafe or unsuitable premises. We did not look at this at our last visit in June 2014 as the provider's action plan following our visit on 13 January 2014 said that all work to the environment would be completed by the 30 September 2014.

Burton, Bridge and Trent Care centre is registered to provide accommodation for 99 people. They can offer support to people with dementia and mental health related conditions. Bridge Court, Burton Court and Trent Court are three separate buildings but are registered with the Care Quality Commission as one location. Bridge Court provides nursing and residential and dementia care to older people. Burton Court provides nursing care to women with mental health related conditions and Trent Court provides nursing care to men with mental health related conditions. All three units are allocated a unit manager.

At the time of our inspection 72 people used the service. On Bridge Court there were 27 people, on Trent Court there were 26 people and on Burton Court there were 19 people.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider advised us that the reason they had not applied to register a manager was because at the time of this inspection an application was in the process of completion to register Burton Court, Trent Court and Bridge Court as three separate locations.

People who used the service and their visiting relatives told us they felt the care was safe at Burton, Bridge and Trent Court. Staff that were spoken to were able to confirm that they understood the principles of safeguarding adults and knew who to report concerns to. However we identified that some of the care practices in the home were not consistently safe.

Although staff that had worked at the home for some time were up to date in most essential training, they were not up to date in all areas and gaps were seen on training records. This meant we could not be assured that people were supported by staff that had received training to deliver care safely and to an appropriate standard.

Sufficient staffing levels were provided although this included the use of agency staff. We saw that actions were being taken to recruit additional staff to ensure a consistent staff team were in place.

Systems in place for recruitment were not suitable to ensure people were supported by staff that were safe to work with them.

We found that the service had to make improvements in order to ensure that medicines were managed safely.

Staff did not always follow the Mental Capacity Act 2005 (MCA) to ensure that important decisions about people's care were made in their best interests when required.

We identified that some people's nutritional needs were not being met because their care plans were not followed.

In all three units we observed occasions when the care provided was not consistent with information recorded in care plans, which meant that people that used the service could not be confident that their assessed needs would be met.

Records were in place to demonstrate that people had access to healthcare services.

Quality checks were in place and had identified areas for improvement but these had not been fully implemented which meant the quality systems in place were not effective.

On Bridge Court we saw that people living with dementia were not provided with clear orientation to enable them to identify their bedrooms as name plates were used on bedroom doors. As people living with dementia were unlikely to recognise their bedroom from written name plates this potentially limited their independence in being able to access their bedroom without support.

On Burton Court because the outdoor seating area was not secure, people that used the service did not have access to this area without staff. This meant that people's freedom to access the outdoor area was restricted.

Summary of findings

People that used the service and their visitors told us that the staff were caring and we saw some examples of this. We also observed some staff practices that required improvement on Bridge Court to ensure that all staff treated people with consideration.

We saw that records were stored securely, with the exception of Bridge Court when we saw that the door where people's care files were stored was left open when unoccupied. This practice meant that people's confidential records were not being stored securely.

We saw that complaints were responded to and people's visitors confirmed this but we did not see any clear process for the timescales in which this should be done by.

You can see what action we told the provider to take at the back of the full version of the report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Recruitment procedures were not followed to ensure the staff employed were suitable to support the people that used the service.

Medicines were not consistently managed safely.

The use of agency staff meant the staffing levels were maintained to enable care to be delivered and the provider was in the process of recruiting additional staff.

People that used the service and their visiting relatives told us they felt the care was safe at Burton Bridge and Trent Court. The majority of staff had undertaken training in safeguarding adults and understood the principles of safeguarding adults and knew who to report concerns to.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff received the training and supervision they needed to ensure they had the skills, knowledge and support required to meet people's individual needs.

The service did not consistently work within the guidance of the Mental Capacity Act 2005 to demonstrate that the relevant people had been involved in ensuring decisions had been made in the person's best interest.

Some people's nutritional needs were not being fully met or monitored appropriately.

People had access to healthcare services and referrals were in general made in a timely way to healthcare professionals, although information in care plans was not always followed to ensure health care professionals were alerted to concerns.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were positive about the way staff treated them. The majority of staff were caring but we saw that people were not always treated with consideration and respect.

People's privacy was respected and people's visitors were free to visit and felt welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

Information in care plans was inconsistent which made it difficult for staff to follow care plans. Some care staff were not aware of information in everyone's care plans. This meant that people's assessed needs were not always met.

People that used the service and their visitors told us that their preferences and wishes were met and people were supported to maintain contact with their family and friends.

Complaints were responded to and people that used the service and their visitors told us that that their complaints and concerns were addressed appropriately.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

There was no registered manager in post and the changes in the management structure had led to inconsistencies in the quality of service provided to people.

The quality monitoring systems in place were not driving improvement in a timely way to ensure people were fully protected from some of the risks associated with unsafe care and practice.

Staff and people that used the service were positive about the management of the home.

Burton, Bridge and Trent 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 was unannounced and took place over three days from the 8 to the 10 October 2014.

This inspection was carried out by a total of three inspectors; there were two inspectors on each day and a specialist advisor and an expert by experience on the first day. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor on the team had experience and knowledge in the mental capacity act, end of life and dementia care and the provision of services for people with a learning disability. 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 by experience on the team had experience in the provision of services for older people. A pharmacy inspector was also part of the team on the second day and they looked at medication management over the three units.

As part of our planning we reviewed information that we held. This included notifications from the provider. A notification is information about important events which the service is required to send us by law. We also looked at information from the local authority regarding their on going involvement; this was following the large number of safeguarding referrals and investigations made this year about the support provided to people that used the service. The local authority were also responsible for contracting and monitoring some people's care at the home. We also reviewed the information received from the fire service regarding the enforcement notice they had served to the provider and the actions needed to meet the required standards. An enforcement notice is a legal document that requires certain actions to be taken to remedy a breach in regulations. The enforcement notice had been served because, although previous requirements had been generally met at Bridge Court, Burton Court and Trent Court continued to be in breach of the fire regulations.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and the area manager advised us that they had not received a PIR to complete. We took this into account when we made the judgements in this report.

During the inspection we spoke with 22 people that used the service, eight people's relatives, four nurses, 18 care staff, the head cook, two activity coordinators, the unit manager at Trent Court, the acting manager and the area manager.

We observed how staff approached and interacted with people receiving care. We looked at 10 care records. We looked at other records that related to the care people received. This included 10 staff recruitment records, the training matrix for all the staff employed and six care staff's induction records. We also looked at the medicines and records for 24 people that used the service, the menus of

Detailed findings

meals provided and the actual meals provided on the three days of the inspection. We looked at the minutes of the most recent staff meeting and six audits of quality checks undertaken since our last inspection in June 2014.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in June 2014 we found gaps in medicines records which indicated that people had not received their medication as prescribed. A compliance action was issued as the provider was breaching Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we found that in general people received their medicines as prescribed and in the way they preferred. We looked in detail at the medicines and records for 24 people living in the home. Records were kept of medicines received into the home and given to people. There were very few gaps on the administration records and any reasons for people not having their medicines were recorded. However we found other areas in medicines management where improvements were required in order to ensure that medicines were managed safely.

People living on Burton and Trent Court who had been prescribed medicines on an as and when required basis, may not have had these medicines given in a consistent way by the nurses as this information was not always recorded. People living on Burton Court and Bridge Court were not always protected against being given medicines that they were allergic to. This was because there were some discrepancies in the information recorded. For medicines that were given regularly but not every day, there was no indication of when one medicine was next due on Burton Court and the nurse was not clear where this information should be kept. This meant that medicines were not always managed in a safe way. This was a breach of Regulation 13 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

Discussions with recently employed members of the care staff team indicated that the correct recruitment procedures had been followed. However on looking at the recruitment records of six care staff that had been recently employed we saw that all of the required documents were not in place within four staff files. This included no application forms on three staff files and no evidence of conduct in previous employment in health and social care services on four staff files from their last employer. This meant that people were at risk of being supported by staff that were unsuitable to work with them as the proper checks had not been undertaken. Following the inspection we received information of concern regarding another member of the clinical team who worked at the service. This was regarding their professional registration. Following discussions with the acting manager it was confirmed that appropriate checks had not been undertaken and this person was working without valid registration. The acting manager took immediate action to ensure this person was relieved of their duties. However this meant that appropriate checks had not been undertaken before staff began work, to ensure the staff employed were suitable to work with people that used the service. This was a breach of Regulation 21 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

At our inspection on 13 January 2014 we identified risks regarding the environment. A compliance action was issued as the provider was breaching Regulation 15 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010. Following our inspection the provider sent us an action plan and told us that all work to the environment would be completed by the 30 September 2014. At this inspection we saw that the majority of refurbishment had been completed. However Staffordshire Fire and Rescue had served an enforcement notice to the provider regarding Burton Court and Trent Court. This was because, although previous requirements had been generally met at Bridge Court, Burton Court and Trent Court continued to be in breach of the fire regulations. We saw an action plan had been put in place by the acting manager, which detailed the actions and timescales required in order for the fire regulations to be met.

At our last inspection in June 2014 people's safety was compromised in Bridge Court by the redecoration that was taking place, which created several hazards for people that used the service. Risk assessments were in place but not followed, this meant that people were not being appropriately supervised to ensure their safety was maintained. A compliance action was left as the provider was breaching Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection all redecoration had been completed and we did not identify any environmental hazards to people that used the service.

People that used the service and their visiting relatives told us they felt the care was safe at Burton Bridge and Trent Court.

Requires Improvement

Is the service safe?

A person living at Trent Court said; "I feel safe here, I can stay in my room when I like because I don't like noisy places"

A person's relative on Bridge Court told us: "I am aware of all the recent concerns here and I have been to the meeting about it, but I don't have any concerns about my mum's care. The staff look after her well and keep her safe."

One person living at Burton Court told us that they felt safe in the home. One person's visitors said they felt that their relative was safe at Burton Court. They told us that they were always called if there was a problem with their relative and said; "I wouldn't put her in any other care home."

At the time of this inspection the Local Authority were working closely with the home due to ongoing concerns in relation to safeguarding adults. Improvements were monitored on a regular basis and people's relatives had been advised by the local authority and the provider of these concerns and the actions in place to monitor and improve the service provision.

Personal emergency evacuation plans were in place for people that used the service. These plans provided information on the level of support a person would need in the event of fire or any other incident that required the home to be evacuated. We saw that the information recorded was specific to each person's individual needs. This meant that staff were provided with the right information to ensure people could be evacuated safely if required.

We spoke to staff about safeguarding people to establish their understanding in what this meant and to see if they had a clear understanding about how to report concerns and who these concerns should be reported to. Staff were able to confirm that they understood the principles of safeguarding adults and knew who to report concerns to. One member of staff confirmed that they had worked at the service for the last five months and said; "I haven't had the training yet but we have had discussions with the manager about safeguarding in meetings and it included who we could go to if we had concerns."

For people at Burton Court that demonstrated behaviours that could put themselves and others at risk we saw that clear guidance was not in place for staff to support people in a consistent way that was safe and protected their rights. For example we observed one person was not supported by staff in a timely way when they demonstrated these behaviours and we observed other people that used the service becoming upset or anxious by this person's behaviour. We spoke with two care staff on Burton Court and one senior carer about how they supported people when they demonstrated behaviours that could put themselves and others at risk. They told us that because they knew people well, they knew what helped to calm them down, such as distraction or diversion techniques. Staff were unable to tell us how they ensured that they used a consistent approach when supporting people with their behaviours and said they were not aware of any behaviour management plans in place to direct them in the correct procedures to follow

On Trent Court we saw that behaviour management plans were in place and followed.

Information in plans was clear and sufficiently detailed to enable staff to support people safely.

We observed staff supporting people using moving and handling equipment such as hoists. We saw that people were supported appropriately and in a safe way. Staff took the time to explain to each person what they were doing and reassured them throughout the procedure.

People and their visitors did not raise any concerns regarding the numbers of staff available to support them.

The level of support each person needed had been assessed to determine the staffing levels required to support people. We saw that staff were available in communal areas and calls bells were answered promptly. Within the clinical team we saw that each shift comprised of nursing staff, senior care staff and care staff. Other staff employed included eight housekeeping staff and seven members of the catering team. This showed that adequate staff were employed to support the running of the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on the 9, 10 and 11 June 2014 mental capacity assessments were in place but these assessments were not decision specific and some did not confirm who had been involved in best interest decisions. A compliance action was issued as the provider was breaching Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

At this inspection improvements had been made in some records seen where decision specific information and best interest decisions were in place. However this was not reflected in all records seen. Some people's records did not show how they were supported to make decisions. Some best interest assessments did not show us how decisions had been reached or that people's families or representatives had been involved in the decision making process. Where people were unable to consent, mental capacity assessments and best interest decision had not always been completed for consent regarding the person's photograph or regarding end of life wishes. This did not demonstrate that the relevant people had been involved in ensuring decisions had been made in the person's best interest. We spoke with two nurses on Bridge Court who confirmed that they had undertaken training on the Mental Capacity Act 2005. However they were unable to describe the processes to follow regarding assessing a person's mental capacity and best interest decisions. Discussions with one person's GP indicated that people who lacked capacity to make health care decisions were not always supported in their best interests. This meant that staff did not have a clear understanding of the processes to follow to ensure that when people lacked capacity to make decisions, they were made in their best interests and in line with legislation. This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010.

At our last inspection in June 2014 the variety and choices of meals available to people did not ensure their nutritional needs and preferences were being met effectively. A compliance action was issued as the provider was breaching Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Information regarding people's nutritional needs and preferences were in place in the care records seen on all three units. Areas of risk were recorded within people's care records and the appropriate actions had been taken in the majority of records seen. However we identified that for one person on Bridge Court their records detailed that they were at high risk of malnutrition and stated that GP advice should be sought if weight loss or change in appetite was noted. Information in this person's records showed that they had lost 7lb in two months. Their care plan review had identified this weight loss but no action had been taken to address this. We spoke to one of the nurses on duty who told us that the GP should have been contacted, weekly weighing should have been implemented and a prescription for food supplements should have been gained. This had not been done. This meant that this person's needs were not effectively met. We also identified that another person living on Bridge Court was not having their dietary needs met appropriately; the information in their care plan was not consistent and not followed. We found that weights for people at Burton Court were not recorded as required to ensure they were monitored effectively and to identify if any actions were needed regarding a person's weight. On Bridge Court we identified that food and fluid records were in place for people but no analysis of information was in place to inform staff when action needed to be taken. This meant that care staff did not have the guidance to follow to ensure actions were taken as needed to make sure people's nutritional needs were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2010.

People that used the service were not always supported by trained staff. This meant that people could not be confident that all staff had the skills required to meet their needs and keep them safe. The care staff employed over the last three to four months had not completed all the essential training stipulated by the provider to ensure they could support people in a safe and effective way. One care worker who commenced employment in July 2014 told us that they had not received training in moving and handling. Moving and handling training is required to ensure that when people require support with their mobility it is provided in a safe way. This person confirmed they had supported people using the hoist with another staff member who had been trained. This meant that this member of staff was undertaking a task that they had not been trained in, this potentially put people that used the service, this member of staff and other staff at risk of injury. Although the other

Requires Improvement

Is the service effective?

staff employed over the last three to four months had received moving and handling training, their training records showed that no other training stipulated by the provider had been provided to them.

The majority of people that used the service that we spoke with and their visitors did not raise any concerns regarding the skills and experience of the staff team. However one person's visitor on Burton Court said; "The staff are very well meaning but they need more dementia training to help them understand how to care for some of the residents." Records showed that less than half of the clinical staff team had been provided with this training to support them in caring for people living with dementia.

The majority of people that we spoke to told us that they enjoyed the meals available. Some people said that they didn't like some meals. We asked them if they were able to have something different. One person on Burton Court said; "Yes you can do if you want, sometimes I don't have much of an appetite so I ask for smaller portions."

People that used the service were asked on the day prior to the lunch time meal for their choices. We saw that staff checked with people prior to the meal that they still wanted what they had ordered the previous day. Staff told us that there was always extra food available in case people changed their mind; this was also confirmed by cook. We observed the lunch time meals on all three units over the three days and the majority of our observations demonstrated that staff were attentive to people that used the service and supported them in an appropriate and dignified way. Any areas for improvement were fed back to the acting manager during the inspection.

Staff responsible for assessing people's capacity to consent to their care, demonstrated an awareness of the Deprivation of Liberty Safeguards (DoLS). We saw that people's rights were protected. Deprivations of Liberty Safeguards (DoLS) referrals had and were being made.

Staff employed in the previous three to four months had limited evidence on file to show they had been provided with an induction. Although staff told us they had worked with more experienced staff and the rotas indicated this, the information held on their induction files did not demonstrate that their competency had been checked during this period or that they had received any formal training.

Staff said they received supervision. One recently appointed care worker told us; "I have also had an informal discussion with the senior carer to see how I am getting on." The records showed that the majority of staff on Trent Court and Burton Court had participated in both group and one to one supervision sessions. On Burton Court only eight of the 29 staff had been provided with a supervision session in 2014 and this was in a group format. This did not demonstrate that all staff were supported appropriately to enable them to meet people's needs effectively.

Records demonstrated that people had access to healthcare services and we saw that referrals were in general made in a timely way to the relevant services when people's needs changed, although as stated, information in care plans was not always followed to ensure health care professionals were alerted to concerns.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on the 9, 10 and 11 June 2014 the individual needs of people at Bridge Court were not catered for in a timely way to ensure their welfare, dignity, privacy and rights were met. A compliance action was issued as the provider was breaching Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this visit we observed some positive interactions between staff and people that used the service in all three units. There was a clear improvement since our last visit in June 4 in the interactions between the majority of staff and people that used the service at Bridge Court. However some observations showed that people were not always treated with consideration and respect. For example one member of staff, on occasions was heard speaking in an abrupt tone to people at Bridge Court. We heard them telling one person that they couldn't access the other communal room or outside but they did not give the person an explanation as to why they didn't want them to do this. We saw that this member of staff on other occasions spoke to people that used the service in a respectful and friendly manner. We fed our observations back to the acting manager to address.

People that used the service in all three units told us that that they liked the staff and that they were friendly towards them.

One person on Trent Court told us; "Staff are very good to me". Another person on Trent Court said; "I don't want to be here but I have no choice, the staff are ok, they help me a lot." A third person on Trent Court said; "Staff are very nice and they help me with things. They take us on trips to the pub and shopping". One person's visitor told us; "He's well looked after here". "The staff are very good". They [the staff] are brilliant with him and me. Very caring, lovely staff".

On Burton Court the majority of people were not able to give us their views of the care they received, however some people were able to confirm that they liked the staff. One person told us; "The staff are nice, I don't have any problems with them." One person's relative on Burton Court told us; "Care is brilliant here." This person said that the staff were very caring and always made them feel welcome when they visited. Another person's relative said; "I appreciate that my mother is difficult to care for but they do a good job in the circumstances."

On Bridge Court one person told us; "The staff are lovely to me, I have no complaints at all." One person's visitor told us; "I don't have any concerns with the care at all, my mum is looked after very well. The only thing I have noticed is the change in staff. My mum's key worker has changed the other one left I think but I'm not sure because I have been told a couple of different things." This indicated that people's families were not always consulted appropriately regarding changes in key staff that worked with their relatives. This relative went on to say; "All in all I think the staff do a very good job and if mum is ill or there are any problems they let us know. "

Although clear improvements in staff practices were seen, we observed a minority of staff practices where people's wishes were not considered. For example two people were supported to sit in the small lounge area. A care worker came in to the room and put the television on saying "loose women that will do". Neither of the two people appeared interested in watching the programme and neither had been asked if they wanted the television on and if they did what they would like to watch. Another member of staff then came into the room and placed a hoist directly in front of the television and then left the room. This means that no consideration was given to these two people regarding their preferences or wishes and demonstrated that people were not always treated respectfully.

We also heard one staff member calling a person using the service a "good girl" and another person using the service was often referred to as "grandma". These references did not demonstrate that this member of staff treated people in a respectful or dignified way.

In general we saw that records were stored securely however on the first day of the inspection we saw that the door to the nurse's office at Bridge Court, where people's care files were stored, was left open when unoccupied. We fed this back to the acting manager during the day but saw that this door remained open when unoccupied throughout the first day of the inspection. This practice meant that people's confidential records were not being stored securely.

Requires Improvement

Is the service caring?

Throughout the inspection we saw that people's privacy was maintained and respected. We saw that in general people were supported to maintain their dignity. However we saw that some people on Bridge Court had stained their clothes whilst eating and they were not supported to change into clean clothes.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on the 9, 10 and 11 June 2014 we found inconsistencies in records at Bridge Court, which meant that people were not protected from the risks of inappropriate and unsafe care. A compliance action was left as the provider was breaching Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that this breach had been addressed as most care plans and risk assessments seen were up to date. However the majority of files included old care plans that were no longer relevant. These were filed alongside new care plans making it difficult to access relevant information. For staff this meant it would be difficult to follow care plans as this information was not easily accessible.

People that used the service and their visitors told us that their preferences and wishes were met. One person on Burton Court told us that they didn't like going out much but liked to spend time in their room. They told us that the staff checked on them to make sure they were alright and said; "I don't mind that, they are just making sure I'm ok which is good." On Trent Court one person was supported to maintain contact with their family via a computer programme, this demonstrated that consideration had been given to ensure this person was able to maintain family links.

We saw that information regarding people's preferences regarding the gender of staff to support them with their personal care needs was recorded. People spoken to were able to confirm that their preferences regarding this were respected and followed.

We were informed by the acting manager that people were supported to maintain links with their faith or culture. One person confirmed that they received visits from their faith representative on a regular basis. We saw that information regarding people's faith or cultural beliefs was recorded in their care files, however in some records it was not clear that people's faith and cultural needs were being met. For example one person's cultural assessment was very clear and confirmed that they had a lifelong involvement in building church communities and had attended church which was very important in this person's life. In the assessment prompt 'what would I like to maintain this' the person recording the assessment had written; 'Nothing - I cannot practice anymore'. This did not demonstrate consideration had been given as to how this person could be supported to maintain links with their chosen faith.

People's visitors told us that they could visit at any time and confirmed that they were asked not to visit at meal times if possible. One person's visitor said; "I tend to visit in the morning so it's not a problem and I think my mum would probably leave the table to see me, or rush her lunch if I came at lunch time, so I think it's a good rule but I'm sure they wouldn't stop you if that was the only time you could visit".

On Trent Court we saw that people were given choices about how they spent their time. Several table top activities had been set up so people could move between them as they wished. Some people were observed sitting chatting with staff and reminiscing about the things they had done, such as past events and their interests and talking about their views and values.

On Bridge Court the activities coordinator was observed spending one to one time with people playing table top games and some group games. We saw that there was a very positive rapport between the activities coordinator and people that used the service. People were very complimentary about the activities coordinator, who was new to the service and told us that they liked him.

On Burton Court we saw the activities coordinator undertaking one to one games with people. Although some people received one to one support from care staff we observed few occasions when people were supported to undertake any meaningful activities with care staff. We did see an opportunity for staff to support a person with an activity they had requested to do. This was a domestic chore and this person was enabled to do this for a short period of time. However the staff member then asked them to stop and told us that this person had only asked to undertake this task because they wanted a cigarette. This person then asked for a cigarette and was told they had to wait whist this staff member completed the task .This meant that this person, instead of being supported to complete this meaningful task before having a cigarette, had to wait, with nothing to do until this staff member was free to support them. This did not demonstrate that people were encouraged to take an active role in choosing and defining activities that were meaningful to them.

Requires Improvement

Is the service responsive?

The needs of the people on the different units varied and the environmental layout and design of each building was different and impacted on the experiences of the people that used the service. On Bridge Court people living with dementia were not provided with clear orientation which may have supported them to identify their bedrooms. This was because name plates were used on bedroom doors. As people living with dementia may have difficulty recognising their bedroom from written name plates this could limit their independence in being able to access their bedroom without support. On Burton Court the outdoor seating area was not secure. People did not have access to this area without staff. We saw that the outdoor area was mainly used by people that used the service that smoked. The activities coordinator said that when people were supported with gardening, their main focus was if they could have a cigarette, rather than enjoying the gardening. This indicated that the lack of a secure garden facility at Burton Court meant that people that used the service associated being outdoors with smoking a cigarette. We also observed people in groups preparing to go outside for a cigarette, which did not demonstrate that people's individual needs were being met by the design of the building but rather that due to requiring staff supervision when outside, people needed to go out in groups to have a cigarette. This demonstrated an institutionalised approached.

We saw that although people's needs were generally met this was not always in line with the information recorded in their care plans and this meant that some identified needs were not being met. When talking to some care staff it was evident that they were not aware of information in everyone's care plans and told us that they did not have time to read everyone's care plans. Staff commented that care planning documentation was "Very burdensome and it takes so much time away from the residents." An example of how staff not following care plans impacted on people's care was seen on Bridge Court. The care plan for one person regarding the risk to them of pressure sores was not being followed. Equipment was not being used as identified in their care plan. This meant that this person was at risk of pressure sores as the correct equipment was not being used.

The relative of one person who lived at Burton Court discussed an incident where their relative had fallen and sustained an injury. They told us that they were not satisfied with the response they initially received regarding the cause of the injury. They told us that they complained to the acting manager and said that they were very satisfied that a full investigation had taken place and it had been managed properly.

The relatives of the people we spoke with on Bridge Court told us that they would raise any concerns they had with the acting manager. One visitor told us, "I don't have any concerns and if I did I would speak to the manager."

Records seen demonstrated that complaints were responded to but we did not see any clear process for the timescales in which this should be done by. The area manager advised us that all complaints went to the providers head office. They told us the information kept on file at the home had only just commenced and said this would be further developed to ensure timescales for responses were recorded.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on the 9, 10 and 11 June 2014 systems were in place but were not effectively monitored and acted upon to ensure people were provided with safe and appropriate care that met their needs and protected their rights. A compliance action was issued as the provider was breaching Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection improvements were seen in some areas but did not demonstrate that the quality monitoring systems in place were driving improvements in a timely way. The acting manager and area manager told us they carried out regular checks to monitor the quality and safety of people's care. One senior member of the care team had been appointed in to a new post specifically for monitoring and observing staff care practices. Their job was to work with staff to further develop the standards of care provided. Audits had been undertaken by the area manager in September 2014, this included care plan audits on each unit. We saw that the area manager had identified where improvements were needed and these improvements were similar to our findings. The information in these audits did not include a timescale for the actions required and we could see from looking at records that the actions in these audits had not been completed. This showed that the systems in place were not effective in ensuring the required improvements were made.

People that used the service spoke positively about the management of the home. On Trent Court two people confirmed that the unit manager was approachable. One person said; "He is ok, I like him and get on well with him." The other person said: "He's a good man; I would tell him if I had any problems." On Burton Court one person that we spoke with was aware that the interim unit manager was off work and confirmed that they knew the acting manager was available to speak to if they needed to. This person said; "She's very nice, I know who you mean and I have a chat with her when she comes over." On Bridge Court people that used the service knew who the manager was and told us that they liked her. One person said; "She's very nice, she often stops for a chat with me."

Consistent leadership and direction for staff had not been in place at Burton, Bridge and Trent Court due to the changes in management both at local level and area manager level. There has been no registered manager in post since February 2014. Since February 2014 two managers had been appointed to oversee the management of Burton, Bridge and Trent Court. The unit manager at Burton Court had changed since our last visit. The area manager for Burton, Bridge and Trent Court had changed since our last visit and the time of this inspection the interim unit manager of Burton Court was on long term leave.

We found that on Trent Court the staff team worked well together and understood their roles and responsibilities and it was evident that they enjoyed coming to work. Staff working at Trent Court told us that the unit manager was approachable and effective and there was a good cascade of communication between the manager and the rest of the team.

We saw that Burton Court did not have the same organisation as Trent Court and although staff were caring towards people, the interactions we observed were not as therapeutic for the people that used the service, other than those being undertaken by the activities coordinator. Staff we spoke with on Burton Court told us that they felt more staff were needed to ensure people's social needs were met.

We saw that there had been some good improvements on Bridge Court regarding people's care but further work was needed on both Bridge and Burton Court to ensure staff were following care plans. To enable staff to do this information needed to be easily accessible and staff needed time within their working day to read information in care plans, which staff told us was not being done.

A care home trainer had been appointed to address the deficit in staff training. We identified that although there was an induction process in place, it was unclear who had been given the responsibility to ensure the competency of new staff had been undertaken and recorded.

Poor recruitment checks meant that a person had been recruited to a professional post that they did not have valid registration to undertake. Although the acting manager took the appropriate action once alerted, this demonstrated that a reactive rather than proactive approach to management was in place. We also identified from this incident that the responsibility for recruitment checks was given to administration staff and had not been overseen or checked by the management team.

Requires Improvement

Is the service well-led?

The provider's own timescales for training were not being met. Training had not always been provided to qualified staff. For example unit managers did not have any dates recorded for safeguarding training. The provider's policy was that medicines training for nurses should be undertaken on an annual basis. We saw that this had not been done for the majority of nurses employed.

Staff we spoke with were aware of the Whistleblowing procedure and their protection under this procedure and this has been used by staff at the home. This demonstrated that staff that worked at the home were aware of the whistleblowing policy and were confident in using this to raise concerns regarding poor practices.

Dining room experience audits had also been undertaken by the area manager and these included the quality of food served, the presentation of food and the presentation of the dining tables and staff support provided. We saw that these audits showed that people were supported appropriately and apart from a few improvement suggestions to some meals served, these audits were positive.

We saw that a full staff meeting was held in August 2014 and the minutes of this meeting confirmed that discussions had taken place with staff regarding changes that would be taking place, such as shift patterns changing. We read that discussion had taken place with staff about not using mobiles phones when on duty and about staff reporting any concerns, without retribution from management. This demonstrated that staff were provided with information from the management team regarding practices and what was expected of them and showed that an open and inclusive culture was promoted at the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not (a) operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person—(i) is of good character,(ii) has the qualifications, skills and experience which are necessary for the work to be performed, and (iii) is physically and mentally fit for that work; (b) ensure that information specified in Schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate; (c) ensure that a person employed for the purposes of carrying on a regulated activity is registered with the relevant professional body where such registration is required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered persons did not protect people that used the service against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Treatment of disease, disorder or injury	(1) The registered person did not have suitable arrangements in place for establishing, and acting in accordance with, the best interests of people that used the service that lacked capacity to consent. (2) Section 4 of the Mental Capacity Act 2005 (best interests) applies for the purposes of this regulation as it applies for the purposes of that Act.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs (1) The registered person did not ensure that people that used the service are protected from the risks of inadequate nutrition and dehydration, by means of the provision of (a) a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs; (b) food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background; and (c) support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. (2) For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.