Parkcare Homes Limited

Jubilee Gardens

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**

Summary of findings

Overall summary

This inspection site visit took place on 7 December 2017 and was unannounced.

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

Jubilee Gardens accommodates 50 people in one adapted building. The home has two floors. It provides residential and nursing care to older people who live with dementia. On the day of our visit 46 people lived at the home and one person was in hospital. The home is located in Castle Bromwich in the West Midlands.

We last inspected Jubilee Gardens in November 2016 and gave the home an overall rating of 'Good'. During this inspection visit we identified a number of areas where standards had not been maintained and there were breaches of the regulations. This is the first time the home has been rated as requires improvement.

A requirement of the service's registration is that they have a registered manager. Since our last inspection the registered manager had left the home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had appointed a new manager who had been in post for nine weeks. The manager was applying to register with the Care Quality Commission (CQC).

The provider did not ensure there were always sufficient numbers of staff available when people needed them and to keep people safe. Staffing levels affected the standard and consistency of care people received and there were often times when there was no staff presence in some areas of the home.

The provider did not ensure risks to people's safety and well-being were consistently identified and assessed. Where risk had been assessed some management plans were not up to date. People's care records were not always up to date or accurate. This meant staff did not have the written information they needed to keep people and themselves safe, including in an emergency. However, staff demonstrated a good understanding of the needs and preferences of the people they supported.

Staff had not completed some of training they needed, including on-going training the provider considered essential to develop and maintain the skills and knowledge required to support people effectively and safely. The management team had not provided staff with opportunities to discuss their role and development.

Management systems to check monitor and improve the quality and safety of the service provided were not always effective. People and relatives had different views about the service provided and the way the home

was managed. Improvements were being made to ensure people and relatives were included in planning and reviewing the care and support provided.

The provider had sought feedback from relatives and staff and plans were in place to use the feedback received to make improvements to the service provided.

People told us they felt safe living at Jubilee Gardens. Staff understood how to protect people from abuse and their responsibilities to raise any concerns. Overall medicines were managed and administered safely. However, some people told us they did not receive their medicine at the times they expected.

Staff were recruited safely and completed an induction in line with best practice when they started working at the home. People received their care and support from staff who they knew. People were not routinely provided with opportunities to take part in activities they enjoyed which were meaningful.

The management team and staff understood the principles of the Mental Capacity Act (MCA) and their responsibilities under the Act. However, some mental capacity assessments and best interest decisions were not in place in line with these principles. Staff gained people's consent before they provided support to people.

People were encouraged to make choices about their daily lives, including what they would like to eat and drink. People with higher dependency needs did not receive the support they required at mealtimes. When needed, people had access to health care service and staff worked with other health professionals to support people to maintain their health and well-being. However, recommendations made by healthcare professional to ensure people's needs were met were not always actioned in a timely way.

Staff respected people's privacy and dignity and supported people to maintain their independence. People who lived at the home were encouraged to maintain relationships which were important to them. Relatives and friends could visit the home at any time. People and relatives knew how to make a complaint and complaints were managed in line with the provider's procedure.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had not ensured there were always enough staff available to support people safely and to keep people safe. The measures to manage risk associated with people's care and support, including in the event of an emergency were not effective. This was being addressed. Staff and the manager understood their responsibilities to safeguard people from harm. Medicines were stored and administered safely. However, some people did not get their medicine at the times they expected. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

On-going and specific training for staff, to ensure they had the knowledge and skills to deliver safe and effective care to people, had not been provided for many staff. Some mental capacity assessments and best interest decisions were not in place in line with the principles of the Mental Capacity Act 2005. Staff understood the importance of supporting people to make as many of their own decisions as possible and seeking people's consent before they provided any care. Staff had been inducted into the organisation. Most people's nutritional needs were met and people had access to health care when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives spoke highly of the staff who they described as 'caring and friendly'. However, staff did not always have time they needed to deliver person centred care. Staff understood how to promote people's right to dignity and privacy at all times. People were supported, where possible, to maintain their independence and relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people's care records were not up to date and did not reflect people's current needs. Action was being taken to address this. However, staff had a good understanding of the needs of people they supported. People were not provided with opportunities to engage in meaningful activities. Improvements were being made to ensure people and relatives were involved in reviewing their care. People and relatives knew how to make a complaint and complaints were manged in line with the provider's procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and relatives had mixed views about the service provided and the way the home was managed. Staff did not receive the support and guidance they needed from the senior management team to carry out their roles effectively and safely. The systems in place to review the quality and safety of service were not effective and required improvement.

Jubilee Gardens

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.

The inspection site visit took place on 7 December 2017 and was unannounced. The inspection team consisted of two inspectors, a nurse specialist and an expert by experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service.

Before our visit we looked at the information we held about the home. We had received information about 'insufficient' staffing levels at night which we were able to check during our visit. We also reviewed the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

We contacted the local authority and clinical commissioning staff to find out their views of the home. They told us they had identified some areas where the home needed to make improvements and were working with the home in relation to these. Commissioners are professionals who may place people at the home, and fund people's care.

During our inspection visit we spoke with eight people, six relatives of people and fourteen staff, including nurses and care staff. We spoke with the newly appointed manager; the home's allocated quality improvement lead and the operations director. We also spoke with a visiting health professional.

We looked at six people's care records and other records related to people's care, including medicine records, daily logs and risk assessments. This was to see how people were cared for and supported and to assess whether people's care delivery matched their records. We reviewed three staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also looked at records of the checks the provider and manager made to assure themselves people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in November 2016 we rated this key question as 'Good'. During this inspection visit we found improvements were required.

On the day of our inspection visit 46 people lived at the home. Care was provided in four units across two floors, three units supported people with nursing dementia needs. The fourth supported people with residential dementia care needs.

We found there were not always enough staff to care for people safely; and people, relatives and staff also told us staff were not always available when people needed them.

When we asked people if they felt there were enough staff to provide the care and support they needed, one person told us, "Staff are always around." However, other people and relatives said, "They are sometimes short staffed… It's so busy at times that you have to wait a bit longer...", "Sometimes there's enough staff and sometimes not. Weekends are the worst times." and, "They could do with more staff. If someone calls in sick they take staff from this unit to cover for them."

Staff we spoke with felt there were not always enough of them to provide care and support to people safely and some felt to keep themselves safe. Some staff told us this was because some people displayed behaviours which they felt scared others and challenged staff.

We looked at records which showed one person became anxious and at times displayed unpredictable behaviours that could cause distress or harm to others. Staff told us during these times they needed to stay with the person which meant staff were not available to support other people who lived on the unit. We identified 13 incidents that had occurred between 2 September and 18 November 2017, some of which had resulted in staff being threatened and harmed.

Staff also told us they felt staffing levels at the home affected the standard and consistency of care they delivered partly due to the number of people whose care and support needs had recently increased. Staff said they did not understand why the number of staff was reduced when people's care needs were the same, particularly in an afternoon.

During our visit we observed a number of occasions where there were not enough staff to meet people's needs and to keep people safe. For example, at 10.30 am there were three people in a lounge where there was no staff presence. Records showed one person was at risk of falls and the second person needed assistance from staff to move around the home safely. This presented a risk because both people were living with dementia and did not understand the risk associated with getting up and moving on their own. A staff member told us, "No-one [staff] is able to sit in lounge with people. We don't have time for that'. They added, "We are still getting people washed and dressed now and it's almost 12 midday." They explained this was because of the level of support people needed.

We saw another person was walking around the dining room close to a 'hot food trolley' which was plugged in and was hot to touch. Again, there was no staff presence. We were concerned because the person had dementia and therefore had a limited understanding that they could be hurt if they touched the hot surface. We alerted staff who assisted the person to go into the lounge.

At lunchtime in another dining room we saw two people seated at a dining table with their meals in front of them. Records showed both people needed prompting from staff to eat. People were not eating their meals. There was no staff presence because all staff working on the unit were supporting people to eat in their bedrooms. After 20 minutes when staff returned to assist the people in the dining room their meals had gone cold. One staff member told us, "Meal times can be very difficult so many residents need help."

When we looked at how medicines were managed. People told us whilst they always received their medicines they were not always provided at the times they expected. One person said, "Sometimes they don't have anyone to give medicines and they have to call in (staff) from another unit to do that." Another person told us they should receive their medicine at 7pm. They added, "But yesterday I didn't get it till 11pm because staff were busy."

We asked the operations director how they determined the numbers of staff needed to support people safely and to ensure people received care and support when they needed it. The operations director told us they used a 'dependency tool' to assess people's level of needs which assisted in establishing how many staff were required. However, they went on to explain the dependency tool was being reviewed because 'the quality of information provided was not a true reflection of need' which meant the tool was not always effective.

Records showed despite the known increase in people's dependency levels staffing had not been increase to reflect this.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing `

The operations director gave immediate assurance that staffing levels would be increased to ensure the safety of people and staff.

After our inspection visit the provider informed us they had reviewed and increased staffing levels and had introduced a 'daily staffing tracker' to evidence the home was being staffed correctly at all times.

Prior to our inspection visit concerns had been raised with us about staffing levels at the home at night. We were told at night time, there should be two staff on each of the four units but on occasions there was only one. On the day of our visit we arrived at the home at 7.15 am so we could check this and speak the night staff before they went off duty at 8am.

When we arrived at the home we were made aware the home was short staffed on one unit. This was because a care worker had left the building during the night because they were unwell. The nurse in charge of the unit told us they had to 'help each other' because they could not get agency cover at that time of night.

When the manager arrived at the home they confirmed they were aware a staff member had gone home due to illness. They told us the staffing levels we found when we arrived were 'an emergency situation rather than custom and practice'. The manager said whilst they pre-booked agency staff to cover planned

absences, arranging agency cover at short notice was 'difficult'. They added, "The problem is not staffing. The problem is staff sickness levels." The manager told us they were addressing this in line with the provider's absence management procedure.

The provider's systems to manage risks related to people's care and support needs were not effective. We found risks associated with people's care were not always identified, assessed and monitored to make sure people and staff were protected from the risk of harm.

One person had epilepsy. Records showed the person had epileptic seizures on the 19 and 27 November 2017 which had resulted in their GP increasing their epilepsy medicine. When we reviewed the person's care records we identified there was no epilepsy care plan or risk assessment in place to inform staff how to manage this risk. However, discussions with staff assured us the person's epilepsy was being effectively managed.

A second person's level of mobility had reduced following a fall and a decline in their overall health. The person now needed two staff to assist them because they were unable to walk. However, the person's risk assessment stated [name] 'walks around the home independently'. This meant staff did not have the information they needed to ensure they supported the person to move safely.

We found by looking at the records and by talking with staff that staff had been moving the person unsafely for a month. This was because a physiotherapist had said the person required equipment to move, and staff had continued to move them without this equipment. Nursing staff had not completed a risk assessment to determine how to move the person safely. The manager told us they were not aware staff were moving the person unsafely and agreed to take immediate action to address this.

Following our inspection the manager confirmed the assessment had been completed and the necessary equipment was in place.

Another person's 'choking' risk assessment scored the person's risk level as low when it should have been high. The person required their food to be pureed; their fluids thickened and had already had an episode of choking which led to aspiration pneumonia. Aspiration pneumonia occurs when food or liquid enters the lungs instead of the stomach. We discussed this with one of the nurses who demonstrated, despite the omission in records, they understood how to support the person safely and gave assurance they would update the risk assessment.

Other records relating to risks associated with people's care had not been completed correctly. Some people's care records included a MUST (Malnutrition Universal Screening Tool). This uses certain information such as people's weight and height to calculate their level of risk of malnutrition. On the files we reviewed we saw two MUST records had not been scored correctly which meant people's risk levels were set lower than they should be. This posed a risk that people would not receive the correct support they needed to maintain their health and well-being.

We asked staff about the action they would take in the event of a fire, or other emergency. One nurse demonstrated they had a good understanding of the homes emergency procedure and their responsibilities. However, other staff told they were not clear about the procedures, particularly at times when staffing levels reduced due to staff sickness. One told us, "I don't know really. We would do our best." Another said, "At training we were told to get people out. If you can't you pull the call bell so the fire brigade know there is someone in their bedroom. It's all up in the air. It needs to be sorted."

Information staff needed to support people safely in the event of an emergency was not up to date. For example, the contingency plan (a document which provides details of people who can be contacted, and what to do in the event of emergencies such as fire, gas, electric or water emergencies) contained the previous registered manager's contact details.

We also found personal emergency evacuation plans (PEEPS) had not been completed for all the people living at the home. PEEPs provide staff and the emergency services with the necessary information needed to support people in the event of a fire or other emergency situation.

Records showed the provider analysed information about incidents that occurred in the home such as 'falls, aggression and inappropriate behaviours' to identify any patterns or trends so that action could take and lessons learnt. However, we found the latest analysis did not included incidents we found during our visit and action had not been taken to address these. The manager told us this was because staff had not followed the correct reporting procedure.

This was a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014. Safe Care and treatment.

We discussed our concerns about the lack of effective risk management and emergency procedures with the manager and quality improvement lead. The quality improvement lead took immediate action to update the fire safety records. The manager assured us they would prioritise updating risk assessments and ensuring staff had a clear understanding of the home's emergency procedures.

After our visit the provider confirmed risk assessments had been updated and staff had been re-issued with a copy of the home's fire procedures. We were also informed fire training had been planned to refresh staff knowledge and the names of fire marshals had been added to the staff rotas. A fire marshal takes responsibility to coordinate the actions that need to be taken in the event of a fire.

Despite the lack of effective risk management people told us they felt safe. One person said, "Yes, I'm safe here with the staff." A relative told us they were confident their family member was safe at Jubilee Gardens.

The provider took action to minimise the risk of abuse or neglect. Staff had attended training in safeguarding vulnerable adults and demonstrated they understood the different types of abuse a person may experience, and their responsibilities to report any concerns. One said, "If I saw bruising I would tell the senior straight away and record it in daily notes. The senior would tell the manager." Another told us, "I would tell the nurse or the manager. If they didn't do anything I would phone social services as I need to make sure people are safe."

We saw medicines were managed, stored, administered and disposed of safely. We reviewed five people's medicines administration records (MAR), which had been completed in accordance with the provider's policy and procedures. Where people's medicines were prescribed on an 'as required' basis there was clear guidance for staff to follow. This meant people received these types of medicines when they needed them.

The provider's recruitment policy and procedures minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to staff working at the home, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to start working at the home until all pre-employment checks had been received and checked by the provider.

The premises and equipment were safe for people to use. The maintenance worker ensured water and electrical checks were carried out within timescales to ensure people's safety.

The home was clean and well maintained. Our discussions with care workers assured us they understood their responsibilities in relation to infection control. One said, "Infection control is very important. We are clear about the need to only use gloves and aprons once and to dispose of them safely. Our observations confirmed these practices were followed which reduced the risk of cross infection. However, three care assistants told us they could not remember completing infection control training. One commented, "I don't think I've done that here."

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in November 2016 we rated this key question as 'Good'. At this inspection we identified areas where the home had previously performed well now required improvement.

Since our last inspection the provider had not ensured all staff had completed the training they considered essential to develop and refresh staff knowledge and skills.

The home's latest staff training record dated 7 December 2017 showed refresher training for a number of staff was not up to date. For example, fire safety, infection control and moving people safely theory. The manager provided further information which identified 36 staff working at the home needed to refresh the practical element of moving and handling training. However, whilst the manager had informed staff this training needed to be completed they had not arranged for the training to take place.

The provider had not ensured all staff had completed the training they needed to meet people's individual needs effectively. For example, one person's records told us they needed to be supported by staff who were skilled in reducing and managing challenging situations through the use of effective de-escalation techniques. Three staff members who frequently provided care to the person told us they had not completed this training and did not feel they had the knowledge and skills to support the person effectively.

This meant we could not be assured staff had the up to date knowledge and skills needed to support people effectively and safely. We spoke with the manager and quality improvement lead about this. They told us they were aware staff training was not up to date and gave assurance training would be scheduled.

Shortly after our visit the provider confirmed moving people safely training had been arranged. They also told us the number of moving people safely trainers at the home was to be increased.

Despite staff training not being up to date people had confidence in the knowledge and skills of the staff who supported them. We were told, "They know what they are doing. I have no problems." and, "They know how to look after us."

Staff had mixed views about the training they received. On staff member told us, "I find it very informative." Other staff felt the training provided was not effective because it, mainly, had to be completed on line using a computer. One staff member told us they found this method of training difficult because they were 'not good on computers'. Another said, "The problem is you can't ask questions if you don't understand something. So you don't learn."

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff told us they had completed MCA training and through discussion demonstrated they understood the principles of the Act. They assumed everyone had capacity to make their own decisions unless it was established they could not. Staff supported people to make their own decisions about their day-to-day care and staff respected the decisions people made.

Staff gained people's consent before they assisted them. We heard one staff member say, "Good morning [name] we've come to help you get washed and dressed, are you ready for us?" The person replied, "'Not quite yet'. So the staff member said, "Ok we'll be back in about half an hour is that ok?" The person replied it was.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Applications had been made to the supervisory body for all people who lived at the home. The manager was awaiting the outcome of some of these applications to ensure people's freedoms were not unnecessarily restricted.

However, some mental capacity assessments and best interest decisions were not in place in line with these principles. We saw an application had been submitted for one person because they had bedrails on their bed which restricted their freedom of movement. This was not reflected in the person's care plans and their file did not contain a related mental capacity assessment or best interest decision. Some files did not have information about who had the legal authority to make decisions about people's finances or health and welfare if the person had been assessed as not having capacity to make these decisions. This information is important so staff know who to speak with when these types of decisions need to be made.

Prior to people moving to Jubilee Gardens the management team completed an 'initial assessment' of people's needs and expectations to ensure these could be met. Some records showed people and their families had been involved in the process. For example, one person had requested their personal care support was provided by female staff. We saw this was reflected in the person's care plan and staff we spoke with knew this. Daily records showed the person's care had been provided by female staff in line with their wishes.

People had mixed views about the quality and variety of food they received. Comments included, I've complained a lot about food. There's an option of three on the menu but there is repetition and you get the same." and, "The food is very nice. There's always a choice."

Records showed staff monitored people's appetites and weight and obtained advice from people's GPs and dieticians if they were at risk of poor nutrition. However, some records relating to people's nutritional needs were not up to date. One person's care plan informed staff the person ate independently. However, we saw the person needed assistance to eat. A senior care worker acknowledged because the information was not correct the person may not receive the consistency of support they needed to maintain their nutritional health. They told us they would update the records.

Despite the omissions in records staff demonstrated a good knowledge of people's nutritional needs and

their dietary requirements. For example, they knew who needed butter and milk to be added to their food to increase the calorific value and who required their food to be pureed. A list of people's individual nutritional needs and food preferences was available to kitchen staff.

Staff worked in partnership and maintained links with health professionals. Records showed staff also supported people to maintain their health through regular appointments with GP's, opticians and chiropodists. A district nurse told us, "Staff do seem to know people well and they recently followed our advice to support one person with diabetes to eat more low sugar food."

However, we saw other healthcare professionals recommendations were not always acted upon in a timely manner. For example, on 16 October 2017 a psychiatrist had advised the home's staff to complete a continuing healthcare checklist. This was because one person's levels of anxiety and the frequency of their unpredictable behaviour's had increased. However, records showed the checklist was not completed until the 7 November 2017 and a further delay meant the checklist was not sent to the person's GP until 30 November 2017.

We checked to make sure people's needs were met by the design and decoration of the home. Directional signage assisted people to move around the home. Memory boxes containing photographs and items that were familiar to the person were located outside bedroom doors. Staff told us this was to enable people to find their rooms independently. Staff also said they referred to the items in the memory boxed to 'spark up conversations' with people.

The manager told us the provider's 'dementia coach' had visited the home in October 2017 and had made recommendations to develop the environment and activities to support people living with dementia, in line with best practice. The manager told us because they were new to the service; they had to undertake specific training before they could act on the recommendations made. They confirmed they had now completed this training.

New staff members received effective support when they first started working at the home. One told us, "My induction was really good. I had two days training and I learned about my job role and all about the company."

Staff told us their induction was in line with Care Certificate and they had worked alongside experienced staff to see how people preferred their care and support to be delivered. The Care Certificate assesses staff against a specific set of standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. This showed the provider was acting in accordance with nationally recognised guidance for effective induction procedures to ensure people received good care.

However, staff had not received on-going individual support (supervision) to help guide them with their work. Comments from staff included, "I've worked here since July. I haven't had one." and, "No, I've never had one." The manager and operations director acknowledged staff supervisions had not taken place and that these needed to be planned.

After our inspection the provider informed us staff supervisions had been planned and would be completed by the end of December 2017.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in November 2016 we rated this key question as 'Good'. During this inspection visit we found improvements were required.

Staff told us they wanted to provide a caring service and they enjoyed spending time with the people they cared for. However, they explained at busy times during the day they did not have the time they needed to support people in the way they wanted. One told us, "You don't have a choice. You have to try to get everything done. It's sad because you don't have the time to do things in the right way."

During our visit, staff on numerous occasions demonstrated their caring and sensitive approach to their work. For example, when one person became anxious a member of staff stopped what they were doing and sat with the person holding their hand and talking to them, until the person appeared less anxious.

However, we saw at other times, when rushed, staff became task focused. For example, during lunch service one person who needed support from two staff to move safely asked for assistance with personal care. Whilst staff responded to the person's request they did so without speaking with the person.

People and relatives told us staff were kind, caring and friendly. One person described the compassion and kindness staff had shown them following the loss of their 'lifelong companion'. They said, "They [staff] were wonderful. They are golden." A relative described staff as "Fabulous and really friendly." They added "They are very good with [person]."

Staff and people had formed caring relationships. We saw genuine laughter and banter between one person and a staff member who was helping them to drink a cup of tea. The staff member said, "You look lovely today." The person replied, "Nearly as lovely as you." We heard other staff asking people if they were comfortable and if they had everything they needed.

Staff interacted with people in a kindly way, crouching down and speaking clearly so they could be heard and understood. Staff also showed concern for people's wellbeing by checking people were wearing their glasses and hearing aids.

Staff understood the importance of respecting people's privacy and ensuring their dignity was maintained. Staff described how one person's behaviours could cause embarrassment to themselves and others. When this happened to protect the person's dignity staff discreetly covered the person's 'lower parts' with a towel and assisted the person to their room so they could be supported with personal care in private.

Staff encouraged and supported people to maintain their independence where possible. For example, they encouraged people to drink from spouted beakers so they were not reliant on staff to help them. One person told us they 'liked' to try to do things for themselves and staff were patient whilst they tried.

People were encouraged to maintain relationships important to them. People told us their visitors were

welcome at any time. One person explained their family members visited frequently and the staff always provided 'a cup of tea' which the person though was caring. A relative said, "I can pop in at any time, and I do."

People had personalised their rooms which pictures, photographs and soft furnishing of their choice. One person told us this gave their room 'homely feel'. We saw people were supported to make everyday decisions and staff respected the decisions people made. For example, some people spent time in their bedrooms, whilst other people spent time in the lounge.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in November 2016 we rated this key question as 'Good'. At this inspection visit we found people's requests for assistance were not always responded to in a timely manner and some care records were not up to date or lacked the detail staff needed to ensure consistent care was provided.

Staff were not always available to respond to people's requests for assistance. For example, we heard one person calling out from their bedroom, "Can I have a drink." The person repeated their request four times. There were no staff in the area to hear the person's request. When we alerted staff to this they responded immediately.

Some care plans did not provide staff with accurate information. This meant we could not be assured people received consistent care which met their needs and preferences. For example, one person's care plans had not been updated following their discharge from hospital despite significant changes in their support needs.

Another person was reliant on nursing staff to change their catheter. The person's care plans stated the catheter needed to be changed every 12 weeks. This conflicted with the information recorded in a 'catheter passport' which stated the change frequency was every eight weeks. We discussed this with a nurse who said they would amend the care plan and put a date in the diary so all nurses knew when the catheter was next due to be changed.

We were concerned the omissions we found in care records meant staff, particularly agency nurses, did not have the information they need to provide safe and effective care to people. The manager told us they had identified care records were not up to date and action was planned to address this, including ensuring the inclusion of relatives in reviews, where appropriate. However, we were concerned some care records need to be updated immediately. The manager told us they would ensure action was taken to address our concerns.

The day after our visit the provider confirmed care plans we had identified as a priority had been updated and that a schedule was in place for all other care plans to be reviewed and updated.

Other care plans detailed people's needs and preferred routines which supported staff to provide personalised care. For example, what people preferred to drink and what items of clothing they liked to wear. Care files contained information about people's life histories, their likes and dislikes, cultural and religious motivations and traditions.

Staff told us they tried to read people's care plans but this depended on how busy they were. They assured us they would report any changes in people's health or anything that could affect their wellbeing to the nurse or manager.

People told us staff who supported them understood their individual needs and said they were overall satisfied with the service they received. One person said, "They know all about me and what I like." Another

said, "The staff are very good. It's not their fault I have to wait it's because they are so busy. I understand that." A relative told us staff had a 'very good' understanding of how their family member wanted their care and support provided. They added, "And they do it the way [person] wants."

In spite of omissions in some care records staff demonstrated they had a good knowledge of people's individual needs, and were able to tell us how people preferred their care and support to be provided.

Staff attended a daily 'handover' meeting at the start of their shift to exchange information about people at the home. Staff told us this assisted them in keeping up to date with people's health and care needs. Handover records were used to communicate important messages and listed key information about each person that lived at the home.

The provider was working in line with recommendations made by The Department of Health's end of life care strategy. The manager told us the home had an identified end of life 'link person'. Their role included maintaining a register of people who lived at the home who were approaching the end stage of life. The link person was also responsible for ensuring people had any medicines they may need as part of their end or life care and support from specialist health care professional.

We found some people had some end of life care arrangements in place, where these had been arranged before they came to Jubilee Gardens, or during hospital stays. The arrangements included decisions that had been made regarding whether people should be resuscitated following a cardiac arrest (DNARCPR).

However, some people's end of life wishes were not clear. For example, one person file contained an end of life care plan stating the person wanted to remain at home and did not want to go into hospital. A DNARCPR showed the person did not want to be resuscitated if they had a cardiac arrest. The person had capacity. However, information in another part of the care file said the person should be admitted to hospital. We asked two staff about the person's wishes. They told us [name] is 'for resuscitation'. This meant there was a risk the person's end of life wishes would not be respected. We discussed this with staff who through discussion confirmed the person's wishes and gave assurance they would contact the GP so records could be updated to reflect these.

People were not always supported to follow their interests and take part activities they enjoyed. They told us, "It's dull. Nothing to do;" "It's boring. I watch TV most of the time;" and, "I read mostly. There are no organised activities, and I don't go out." A relative commented, "It could be a bit livelier. They need more entertainment."
During our visit we saw the activities co-ordinator inviting people, on two units, to help put up the decorations in preparation for the Christmas. On another unit people spent their time watching television and painting pictures which they said they enjoyed. We saw several people spent time stroking the home's cats. One person told us they liked cats. They added, "I like giving them a bit of fuss."

However, at other times across all units we saw people were not engaged or stimulated in any activities. A staff member explained they did try and provide activities such as painting people's finger nails and holding a sing along sessions but they could not always do this as they were busy providing care to people.
We checked how complaints or concerns were managed by the home. People and relative's told us they knew how to make a complaint and would feel comfortable doing so. One person told us they would 'tell staff' if they had a complaint. Discussion with staff demonstrated they understood their responsibilities to support people to share concerns and make complaints.

We saw the provider's complaint procedure was displayed in the home and a 'comments and concern' book

was available in the front reception. There were no recent entries. Since taking up post, the manager has also sent copies of the provider's complaint procedure to relatives and had reminded them of the 'comments and concern' book. Records showed eight complaints had been received since our last inspection which had been managed in line with the provider's procedure.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in November 2016 we rated this key question as 'Good'. During this inspection visit we found improvements were required.

Since our last inspection there had been a change of management at the home. The previous registered manager had left their employment in October 2017. Prior to leaving they had worked, for a short period of time with the newly appointed manager. At the time of our inspection visit the new manager had been in post for nine weeks. They told us they had begun their application process with CQC to become the registered manager.

Since taking up post the new manager had received regular support and guidance from one of the provider's quality improvement leads and the operations director who were part of the management team. The manager told us active recruitment was taking place for the position of deputy manager.

The management team's oversight of the home did not assure us that people were always cared for safely, and staff were provided with enough guidance and support. For example, it had been identified that the home was no longer able to meet one person's needs. The manager had met with the person's family and alternative accommodation was in the process of being sought. However, in the interim, arrangements had not been made to manage the person's care needs whilst ensuring the safety of the person, other people and staff.

The management team had not ensured staff received the support and guidance and all the training they need to effectively and safely fulfil their roles.

Most staff told us they did not always feel supported and valued by the provider's senior management team. They explained this was because they felt managers did not understand what it was like to provide the care people needed and communication was not always effective. One commented, "It would be really good if all of the top managers came and worked with us for one shift to see the challenges we face." Another told us they felt frustrated because when changes happened at the home the reasons why were not always explained to them. Other staff told us they did not find the management team approachable and they lacked confidence to speak with them.

Prior to our inspection visit a commissioner had informed us they had identified areas that required improvement at the home. In response to this the management team had developed a quality improvement plan detailing the improvements needed, the actions taken, or to be taken and the timescales for completion. For example, we saw a meeting had been held with people's relatives and future meetings were planned to assist in improving communication between them. One relative told us they had found the meeting, "Very helpful."

However, we found the plan did not prioritise actions needed to ensure the safety of people who lived at the home and the staff. For example, the plan identified the need to 'complete audits for all care files and act

upon any shortfalls' by 15 December 2017. During our visit we identified significant omissions in people's risk assessments and care plans which required immediate attention. We discussed this with the operations director who told us they would prioritise reviewing and amending the plan.

The provider used a range of audits and checks to monitor the quality and safety of the service provided and to identify where improvement was needed. For example, a medicine audit identified the action needed and being taken to ensure daily temperature checks of the medication room were not being completed.

However, the provider's audits and checks were not always effective. For example, checks of fire safety at the home had not identified staff did not have the information they needed to support people safely in the event of a fire or other emergency and arrangements to ensure there were enough staff on duty to meet people's needs was not effective. Other checks had not been completed and action had not been taken to address areas identified for improvement. For example, the provider's 'monthly infection control checklist' had not been completed since June 2017 and actions from a health and safety audit completed in July 2017 remained outstanding. The operations director acknowledged auditing was not up to date. They told us action was planned to address this.

We found some of the provider's auditing processes were not sufficiently detailed to make sure they were effective. For example, the audit tool used to check the management and administration of medicines did not included the requirement to check stocks of medicine in the home. This is an important aspect when auditing medicines to ensure medicines are being administered as prescribed. We discussed this with the manager who told us, "I agree. We are looking at our audits.

This was a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Relatives told us they were not confident the home was well-managed. One said they had a number of concerns about the care provided to their family member and were meeting with the manager on a monthly basis to address these. They added, "Things have got better."

When we asked staff if the home was well-managed they commented, "Management keeps changing so it's hard to say.", "Managers don't seem to stay very long, everything keeps changes depending on their style." and, "I guess the manager is ok let's see how it goes."

A relative's satisfaction survey was available in the front reception of the home. The manager had also issued a quality questionnaire to family members and staff inviting them to share their views about the home and to make suggestions about 'things the home could do better'. The manager told us they were planning to use feedback from these to further develop the service and address areas where improvements could be made.

Since taking up post the manager had met with staff. Minutes of the meeting held on 22 November 2017 showed a range of topics had been discussed including, training, staff absence, the home's quality improvement plan and activities. One staff member told us if they were unable to attend the meeting they could 'catch up' because the meeting minutes were available for them to read. The manager told us they were planning to vary the times of staff meeting to ensure all staff had the opportunity to attend.

Staff spoke positively about the support they received from senior care workers and nurses. One said, "The nurses are brilliant, they are always happy to help and provide good advice."

We asked the manager about their understanding of the legal requirement to submit statutory notifications about important events and incidents that occurred within the home. This was because we had recently received numerous duplicate notifications. They told us this had occurred because being new to the provider they had not been fully familiar with the provider's processes. They said this had been addressed.

The manager and quality improvement lead were not familiar with the 'Accessible Information Standard' [AIS]. The AIS aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need. They acknowledged this was not something they had yet considered at Jubilee Gardens, but assured us they would attend to this as they completed the review and update of all care plans.

Providers are legally required to display the ratings we give them, within the home and on their website, within 21 days of receiving our final inspection report. We saw the provider's website showed the home latest CQC rating. However, the rating poster on display in the reception area was from the inspection visit we had conducted in 2014. We brought this to the attention of the manager who updated the poster.

After our inspection visit we spoke with the provider's new director of performance and regulation who gave us assurance they would be acting swiftly on the concerns we had identified during our inspection. They sent us information outlining the immediate actions they had taken or were planning to take to respond to our concerns and to improve the quality and safety of care provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) HSCA RA Regulations 2014. Safe care and treatment The provider did not ensure care and treatment was always provided in a safe way. The provider had not ensured all risks associated with people's care and support needs were assessed, monitored and reviewed. The provider had not ensured where risk had been assessed that records provided staff with the up to date and accurate detail they needed to manage and reduce risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) (2) (a) (b) (c) (f) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The providers system of governance did not provide sufficient assessment and monitoring of risk to mitigate the risks to the health, safety and welfare of people who lived at the home and staff. Records relating to people's care did not always

contain up to date and accurate information about people's care needs.

The provider had not ensured staff received the guidance, training and support need to fulfil their roles effectively and safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) HSCA RA Regulations 2014. Staffing The provider has not ensured there were always enough staff available to keep people safe and to support people when needed. The provider did not have an effective system in place to determine the numbers of staff needed to meet people's needs and to keep them safe at all times.