WCS Care Group Limited

Castle Brook

Inspection report

Castle Brook
Common Lane
Kenilworth
Warwickshire
CV8 2EQ

Tel: 01926856710
Website: www.wcs-care.co.uk

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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

Castle Brook provides accommodation and personal care for up to 84 older people who may live with dementia. Sixty-three people were living at the home at the time of our inspection visit. This was the first comprehensive ratings inspection since the service was registered on 2 December 2016.

There were two registered managers for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

One registered manager had been appointed when the service was first registered in December 2016. They no longer worked at the home on a day-to-day basis, but retained managerial oversight of this and one other service in the provider's group.

The second registered manager had transferred from another home in the provider's group and had registered at this service in May 2017. When our inspection started, the second registered manager was responsible for the day-to-day management of the service and for the direct supervision and management of staff. We have referred to the second registered manager who had day-to-day responsibility for the service as 'the home registered manager' throughout this report.

During the course of our inspection, the home registered manager stopped working for the provider and an acting manager was appointed to take responsibility for the day-to-day management of the service. The provider has notified us of these changes in how the home was managed.

The service was delivered over three floors, which were subdivided into six individual households for up to 14 people. Each household had their own communal lounge, kitchen and dining areas and people had access to the shared facilities in communal areas throughout the home.

Medicines were not administered or managed safely. The home registered manager had not followed the provider's guidance for managing and administering medicines safely in accordance with best practice. During our inspection visit, the provider took immediate action to improve how medicines were managed and administered.

Staff understood their responsibilities to protect people from the risk of abuse, but the home registered manager did not demonstrate understanding of their responsibilities. They had not always referred people to the local safeguarding agency promptly or notified us when they made a referral. The acting manager told us they would ensure statutory notifications were sent to us when required in future.

There were not enough, consistent oversight of agency staff's practice to ensure their skills, experience and behaviour was of the same standard as permanent staff.

Staff were not consistently supported or supervised by senior staff they trusted and respected. Staff had not had the opportunity to reflect on their practice or consider their career development.

Improvements were required in identifying, responding to and analysing complaints.

The provider's quality assurance process had not identified the extent of poor management of the service or the impact it had on people's perception and experience of the service. When the provider was made aware of concerns about how the service managed, they took immediate action to investigate and improve the quality of the service.

Risks to people's individual health and wellbeing were identified and care was planned to minimise the risk. People, relatives and staff felt the low number of permanent, sufficiently skilled staff was a risk to delivering safe care and support.

The premises and equipment were regularly checked to ensure they were safe for people to use.

The provider checked staff's suitability for their role before they started working at the home. During our inspection, they took immediate action to make sure all agency staff were also suitable and appropriately skilled to deliver safe care and support.

Records showed the home registered manager understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. They had applied to the supervisory body for the authority to restrict people's liberty to keep them safe. Staff understood their responsibilities in relation to the Act and checked that people consented to be cared for and supported.

People were supported to eat and drink enough to maintain a balanced diet that met their individual dietary needs and preferences. People were referred to healthcare services when their health needs changed.

Staff were caring and compassionate, but there were not always enough regular, known staff on duty to make people feel consistently valued. Staff told us they had not felt cared for or supported until the provider had appointed an acting manager.

People were supported to maintain their preferred and familiar routines and habits, but clubs, planned entertainments and events were not always held where people felt comfortable to attend them.

People, relatives and staff told us the service was not consistently well-led. The home registered manager was not proactive at obtaining feedback about people's experience of the service.

Communication between staff and the home registered manager, and between relatives and the home registered manager, was not effective. People, relatives and staff were not confident that issues raised were taken seriously and were not advised how they would be resolved. The acting manager took immediate action to improve communication across the whole home and between all the individuals who had an interest in how the home was managed.

We found 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. Medicines had not been managed and administered safely. Staff understood their responsibility to share concerns, but the home registered manager had not referred concerns to the local safeguarding body when required. People's individual risks were identified in their care plans, but senior and lead staff did not consistently ensure risks to people's health and well-being were minimised. Risks related to the premises were minimised by the provider's system of checks and regular maintenance.

Is the service effective?

Requires Improvement

The service was not consistently effective. The prolonged use of agency staff since the home opened had led to inconsistency in staff's effectiveness at delivering care and support. There were not enough experienced senior staff to oversee staff's practice and to share information with relatives. The home registered manager and staff understood their responsibilities under the MCA 2005. People were not consistently supported to enjoy their meals. People were supported to maintain their health and access to healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring. Some staff did not work at the home regularly enough to know people well. The provider's systems, that promoted a person centred service, were not implemented effectively by the home registered manager. Staff did not feel consistently cared for, supported or empowered to deliver person centred care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People with less complex needs were able to maintain their preferred routines. People with more complex needs did not always receive a consistently responsive service. Concerns and complaints had not always been responded to effectively, or to the individual complainant's satisfaction. The home registered manager had not acted in accordance with the provider's complaints policy and process.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. People's views of the service had not been sought or taken into account about how the home was managed. Communication between people, relatives, staff and the home registered manager was ineffective. The acting manager took immediate action to improve communication. The provider's quality assurance process had not identified the extent or impact of poor management of the service. The home registered manager had not always acted in accordance with their legal responsibilities.

Castle Brook

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 checked 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 planned comprehensive inspection took place on 12, 13 and 22 September 2017. The inspection visit on 12 September included two inspectors, an inspection manager and two experts by experience and was unannounced. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of care service. We told the provider one inspector would return on 13 September and two inspectors would return again on 22 September 2017.

We allowed time between our inspection visit dates to enable the senior management team to conduct an independent investigation into concerns they had received, the weekend before our inspection, about how the service was being managed. An acting manager had been appointed from the senior management team to manage the home, the day before our inspection visit commenced. We were not able to speak with the home registered manager, so we spoke with the acting manager throughout our inspection.

Before the inspection visit, the provider completed 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. In the PIR, the provider told us they had already identified some aspects of the service that required improvement and explained the lessons they had learnt for the future.

We also reviewed the information we held about the service. We looked at information received from relatives, healthcare professionals and the local authority commissioners and reviewed the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

During the inspection we spoke with 11 people who lived at the home and 15 relatives. We spoke with 17 care staff and two support staff about what was like to work at the service. We spoke with the acting

manager, the first registered manager and four members of the provider's management team including a service manager, the marketing manager, a trainer, the chief executive and a director of delivery and innovation.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us to assess if people's needs were appropriately met and whether they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We observed the care and support staff gave to people in communal areas of the home and we observed how people were supported to eat and drink at lunch time. We reviewed extracts of nine people's care plans and daily records to see how their care and treatment was planned and delivered. We reviewed records of the checks the management team made to assure themselves people received a safe, effective quality service.

Requires Improvement

Is the service safe?

Our findings

The home registered manager had not ensured medicines were managed and administered safely. This was a breach of the regulations. People told us they had not always been supported to take their medicines when they needed them. People told us, "I don't get it (medicine) at regular times. I'm supposed to get one medicine before I eat, it comes afterwards sometimes" and "There's an antacid tablet I normally have to take by 8.00am before breakfast. On Sunday I didn't get it until 10.45am because they were short-handed."

Staff told us that there were not always enough staff on each shift who were trained in medicines administration. The provider's policy stated medicines could only be administered to people by trained staff. This meant the trained staff had to administer medicines for more than one household, which caused delays in administration, due to the number of people who needed medicines. A member of staff told us, "The morning medicine round starts about 9.30am and can go on to 11.30am." They confirmed that the lunchtime medicine round could start less than an hour later, around 12:30pm (when they administered medicines for two households). Another member of staff said, "Medicines rounds take so long that there is not sufficient gap and staff are frightened of overdosing people. Sometimes two staff do medicines for whole home (six households)." The medicines administration records (MAR) being used at the home did not state the actual time medicines were administered. Staff recorded when they administered medicines against the time periods of 'breakfast, lunch, tea and bed' time. The provider could not be confident there was a sufficient gap between each medicines administration.

The Medicine Administration Records (MAR) dated August 2017 for another person who was prescribed medicine which should be given before they ate, was not marked to state this medicine should be 'given before eating'. Four medicines listed for this person were not signed by staff on 21 August 2017, to say they were administered, which meant the provider could not be confident the person had received their medicines. One person's MAR sheet for August 2017 was marked by staff, "Chase paracetamol as not had any for few days, which meant the person might not have been able to have their pain relief medicine when they needed it.

The home registered manager had delegated the responsibility for medicines management to junior staff who had not been trained in safe management of medicines. Prior to our inspection, we received information of concern from the clinical commissioning group about how medicines were being managed. The concerns included how medicines were ordered, monitored and disposed of. They had received repeat prescription requests for people who no longer lived at the home. Some medicines had been sent back to the pharmacy although people still needed them and other medicines had been ordered even though they were not needed, which resulted in wasted medicines.

This was a breach of Regulation 12(1)(2) (g) HSCA (RA) Regulations 2014 Safe Care and Treatment.

The acting manager told us they had received an allegation that medicines were not being managed safely and effectively two days before our inspection visit started, and as such, took immediate action two days before our inspection started. By the third day of our inspection, the provider had completed a full audit of

medicines. The home registered manager had not overseen staff's practice to make sure medicines management was safe and effective.

By the third day of our inspection, the newly appointed acting manager had taken action to improve how medicines were managed and administered. They had reviewed and updated the staff rotas, to ensure there were always enough trained staff to administer medicines safely. Where there were gaps in availability of trained staff, senior staff were allocated to administer medicines. Staff told us this was effective because they had not been asked to administer medicines for more than one household during the previous week. Some staff had attended refresher training in medicines administration. Staff who administered medicines were checking each other's practice three times a day to ensure safe procedures were observed.

The Acting manager had reinstated the provider's established procedures for safe medicines management across the home. Only senior staff, who had the required training, were responsible for ordering and disposing of medicines, with regular oversight from the acting manager. Errors in medicines administration that had been overlooked by the home registered manager were uncovered by the acting manager's audit. They said they would send us statutory notifications to advise which individual's health had been compromised, because they had not received their prescribed medicines as required.

Improvements were required in managing safeguarding concerns. Permanently employed staff received safeguarding training to make sure they understood the signs that might indicate a person was at risk of abuse. Staff told us they had raised concerns with senior staff and the home registered manager during the past few months, but had not received any feedback about actions taken by the home registered manager. Records showed the home registered manager had not always referred concerns to the local safeguarding team promptly.

The home registered manager had delayed making a referral to the local safeguarding team related to an allegation of abuse to a service user by a member of agency staff. The person was no longer at risk because the home registered manager had stopped the agency staff from working at the service straight away and had reported the allegation to the agency. However, they had not made a referral to the local safeguarding team until a month after the allegation, which had delayed their investigation. The home registered manager had not notified us, in line with their legal responsibilities, when they had made the referral to the local safeguarding authority.

This was a breach of Regulation 13(1)(2) Safeguarding service users from abuse and improper treatment.

People told us they felt safe because the premises were secure. People told us they were able to lock their bedroom doors so only staff could enter them if they wished. People told us they felt safe because they trusted the staff to keep them safe. One person told us they did not always feel safe from other people at the home. They knew some people with complex needs were unpredictable in their behaviour, which they found alarming. They told us they were not confident there were always enough staff on duty to keep them safe from other people's unpredictable behaviour. On the second day of our inspection visit the person had shared their concerns with the acting manager. The acting manager had listened to their concerns and invited them to move to another household within the home, to make sure they felt safe.

Improvements were required in ensuring there were enough suitably skilled and experienced staff to support people safely. People, relatives and staff told us there were frequently not enough permanently employed staff on shift to be confident that risks to people were minimised. Some people told us they sometimes had to wait to be supported with personal care and for their medicines. A relative told us, "Wednesday is often a bad day, sometimes [Name] still isn't up at 10am. When I asked a carer about it I was

told, 'I'm busy at the moment, we are doing a double'."

Staff told us some agency staff were regular and worked in the same way, to the same standards as permanent staff. These agency staff are considered as 'temporary' staff, because they worked regular hours at the home and knew people as well as permanent staff. Staff in the re-ablement household, where people stayed for short periods before returning to their own homes, told us they always had the same consistent team of staff.

The provider understood one of the challenges in opening a new home would include recruiting enough staff with the right skills. Prior to our inspection, the provider told us they had underestimated the number of new people who wanted to move into the home for residential care, combined with their plan to provide 13 rooms for the local health trust to support people with a re-ablement package to return to home after being in hospital. They had appointed 22 new staff since 17 April 2017, but their planned recruitment had not kept pace with the rapid increase in numbers of people living at the home permanently and temporarily, so they had needed to use agency staff.

The provider had taken action the day before our unannounced inspection visit to resolve the concerns about people's safety through the use of enough appropriately skilled staff on each shift. They had appointed an acting manager from their senior management team, with sufficient experience to improve how the home was staffed. The acting manager had increased the number of senior, or lead care staff, on each shift from three to six. They had a meeting with the staff agency and agreed a strategy and protocol to ensure people were supported by consistent staff with appropriate skills to minimise risks to people's safety. The acting manager had advised the staff agency, they would hire only named agency staff after reviewing a profile of their skills, training and experience. All the agency staff they used in future would have to attend two induction sessions at the home, to include the in-house health and safety and operational processes training.

The provider continued to recruit permanent staff to reduce the need for agency staff. The provider's regular recruitment process for permanent staff included making all the pre-employment checks required by the Regulations, to ensure staff were of good character and suitable to deliver personal care.

The continuous use of agency staff meant that people and relatives felt their individual risks were not always managed. People's care plans included risk assessments related to their individual and diverse needs and abilities. Care plans explained the equipment and the number of staff needed, and the actions staff should take, to minimise risks to people's health and wellbeing. All the information in the care plans was available to all staff electronically in hand-held devices they carried with them. People and relatives told us regular staff understood their individual risks and took appropriate actions to minimise their health and practical risks. They were concerned only that some agency staff did not read the care plans or understand the actions they should take, but instead relied on being told or shown by regular staff.

The provider's policies to keep people safe included regular risk assessments of the premises and testing and servicing of essential supplies and equipment. Most staff received training in health and safety, first aid and fire safety, to ensure they knew what actions to take in an emergency. Agency staff told us they had an induction to the service and were aware of fire exits and emergency procedures. Records showed the fire alarm system and fire-fighting equipment were regularly checked. Two people told us staff had reassured them when the fire bell was tested and the staff attended the fire drill meeting. The 'fire folder' in reception listed everyone who lived at the home, and explained the support they needed to mobilise, to ensure people could be supported safely if they needed to evacuate the home in an emergency.

Requires Improvement

Is the service effective?

Our findings

Improvements were required in how staff were supported to be effective. People's experience of staff's effectiveness was inconsistent. People's experience differed in each household, according to the ratio of permanent and temporary staff to irregular agency staff. The home registered manager had not allocated enough senior staff to oversee staff's practice. Staff were promoted to lead and senior roles without the required training or experience. By the end of our inspection, improvements had been made, but people and relatives needed time to be confident that the improvements would be sustained.

One person told us, "This morning they [staff] didn't come until 10.00am to wash and dress me. Normally I've had my breakfast by then." Relatives in four out of the six households were concerned that irregular agency staff did not have time to get to know their relation well enough to be effective or to support them in accordance with their agreed care plan. Relatives reported occasions when their relations had been offered unsuitable food and drinks by agency staff. One relative told us only one permanent member of staff seemed able to encourage their relation to maintain their personal hygiene. They told us permanent staff understood their relation's needs, but they did not have time to constantly monitor how agency staff supported and engaged with their relation.

Other relatives told us communication about their relation had been minimal. They identified this was because too many of the agency staff did not work regularly at the home and did not have the same knowledge of people and did not feel the same level of responsibility for people's wellbeing as the permanent and regular agency staff. A relative told us, "There is little supervision of staff to motivate and drive. It needs qualified, professional oversight." Staff in four of the six households told us they felt 'exhausted' because they carried the responsibility for irregular-agency staff's actions. They explained these staff did not always demonstrate the required skills and behaviours to support people's well-being.

On the first day of our inspection, we saw agency staff did not always receive the leadership they needed to be effective, because permanent staff were busy and there was little supervision by lead or senior care staff. The home registered manager was responsible for ensuring agency staff understood how to support people effectively by supervising their practice. Staff told us agency staff were not supervised effectively because so many of the lead, or senior care staff were inexperienced at supervising staff.

All of the staff we spoke with reported that staff were not supported effectively by senior care staff, either because there were not enough of them, or because they did not have the right skills and experience to manage and supervise staff. Staff told us, "We are trying to have our own staff on each household", "There is not always a lead on every rota, they might be part days" and "The duty manager was often a lead care, with no experience (of staff management)." None of the staff we spoke with had attended one-to-one supervision meetings with a line manager since the home opened in December 2016. Some staff did not know who their line manager was and had not attended any staff meetings since they started working at the home.

A long-term employed member of staff told us, "It has been challenging at this home with a high agency staff

and numerous starters, and some leave. It's been a bit of a ride. Staff have been promoted without training, they have responsibility without experience and not enough staff in total." Relatives told us that in July 2017, the home registered manager had assured them that the ratio of agency to permanent staff would always be one to two, but that had not always happened in the household their relation lived in. They said unknown agency staff had continued to work without effective leadership from permanent or senior staff.

New staff studied for the Care Certificate, which includes training in the fundamental standards of care, when they started working at the home. However they were not consistently supported to improve their skills or confidence in their role by the home registered manager. One member of staff who had recently completed the Care Certificate told us they had not been given their certificate and had not been invited to a one-to-one meeting with a line manager to sign off their training, reflect on their practice or to consider their career options.

The provider expected permanently employed staff to attend training in subjects that were relevant to people's needs, to enable them to be effective. The provider regularly updated the training available to staff to support their practice, but not all staff had been booked on to training courses in accordance with the provider's guidelines. Some staff said they had not attended refresher training 'for years'. The provider's training statistics showed only 39% of care staff had attended refresher training in moving and handling and only 18% of care staff had attended refresher training in food safety.

This was a breach of Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing.

Ahead of our inspection, the provider had appointed an acting manager, supported by another member of the management team to manage, lead and supervise staff. The acting manager showed us a list of scheduled supervision meetings with staff, which demonstrated they had not taken place in accordance with provider's guidance for supporting staff. The acting manager told us they would schedule meetings with each member of staff, to ensure they had the opportunity to share any concerns, to reflect on their practice and consider their personal development. The acting manager told us they would take action to make sure staff attended the refresher training they needed for their role, in accordance with best practice guidance.

In one household, which was consistently staffed by permanent staff, one person told us the service was effective. They told us their needs, abilities and preferences were understood by staff, who had the right skills to support them effectively. In another household, where the same temporary staff had been working regularly since the home opened, people received consistent care and support. A relative of a person who lived in this household told us their relation had been supported effectively to maintain the same routines and habits as they had always followed, which meant staff understood the person's needs well. They told us, "We have no worries with [staff Name] or [staff Name], but there is no single point of contact. It needs a coordinator. Staff are always busy and haven't got time."

The acting manager had revised the staff rotas to ensure there were always permanent staff on each shift and in each household. The acting manager had changed senior staff's roles and responsibilities, to ensure there were enough sufficiently qualified and experienced staff to lead the staff team on each shift and in each household. Previously, three care team managers had been responsible for supervision of two households on the same floor. By the third day of our inspection, this was changed to six care coordinators, each responsible for only one household of up to 14 people, to act as a single point of contact for people and relatives.

The duty manager's office had been moved from an-out-of-sight office on the middle floor, to the ground

floor, where they were visible and accessible to people and relatives. The acting manager and a member of the provider's management team attended handover, to ensure they were kept informed of changes in people's needs. Staff told us they had already noticed improvements in how staff were supported to be effective, because the management team were visible, approachable and hands-on.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The home registered manager and staff understood their responsibilities under the Act. The home registered manager had applied to the local authority for the right to deprive 40 people of their liberty, because they did not have the capacity to recognise risks to their safety. All the applications were waiting for the local authority's written approval at the time of our inspection.

People told us they made their own decisions about their day-to-day care and support and staff respected their right to decide. In the re-ablement household, staff were very clear about their role. A member of staff told us, "We are enablers, not care staff. We build up their confidence and strength." One person who lived in that household told us they made all the decisions about their care and support and felt 'in charge' of their life decisions. In other households, people told us they got up and went to bed when they preferred decided how they spent their time. One person assured us, "I'm quite free to do what I want."

The provider employed dedicated hostesses to prepare and serve the midday and tea time meals. The menus were planned to offer a nutritionally balanced diet, with a choice of up to five main meals and two puddings every day, and a choice of hot or cold evening meals. People were asked about their preferences and any dislikes or allergies when they moved into the home. A member of the provider's management team told us this information was taken into account when planning the menus. They told us the supplier's range included meals specific to people's individual needs, for example, gluten free, sugar free and meals specific to people's cultural or religious traditions.

Lunch was served at different times in the two households on each floor. People made choices about when and where to eat. One person told us they always went to the 'other' household for lunch because it was served at their preferred time. Most people we spoke with were happy with the variety and amount of food available to them. People told us, "The food is lovely, lots of choice" and "You always get enough. I reckon the choice is good, five choices today." Relatives had various concerns about the meals, in particular that vegetables were not cooked how their relation preferred, that meals were provided too close together in the day and that the breakfast staff's skills were variable. Some people told us the meals were, 'a bit the same', but no-one had any concerns about the amount of food available. We reminded relatives they should share their feedback with the provider on their relatives' behalf.

People were offered hot and cold drinks throughout the day and had a choice of meals that met their needs. At lunchtime, people who were able to walk over to the serving area were able to look at the variety of food available and make a choice about what to eat. For people with more complex needs, staff showed them the menu and explained the options available.

On the first day of our inspection, we saw some staff had not understood nor acted in accordance with the provider's guidance for ensuring people enjoyed a good lunchtime experience. For example, we saw a member of staff poured gravy onto everyone's meal, whatever meal they had chosen, without asking them first. We told the provider what we had observed. By the third day of our inspection, the staff's practice had been observed by a member of the management team, and they had been reminded that people should always be offered choice in everything. We saw the gravy jug was on the table for people to help themselves

or with assistance from staff.

Staff were encouraged to sit and eat their lunch with people in the dining rooms, which made lunch a social occasion, and encouraged, supported and reminded people to eat where people required help with this. Staff monitored people's appetites and weight and obtained advice from people's GPs and dieticians if they were at risk of poor nutrition. The electronic care planning system raised a red alert to the management team if people were not weighed regularly, or did not eat well, or if their weight dropped out of an appropriate range for their height, age and health condition.

Staff supported people to maintain their health through regular appointments with healthcare professionals, such as dentists, opticians and chiropodists. People told us, "I've seen the doctor here" and "I get my nails done regularly." A relative told us, "They sent a carer to the hospital with him when he had to go". Staff were able to print out a hospital information pack which included the last 48 hours' care story, risk assessments and the previous 48 hours fluid consumption to ensure essential information was shared with the hospital.

People in the re-ablement household were directly supported by healthcare professionals from the NHS healthcare trust that commissioned the service. The NHS trust healthcare professionals had their own on-site office, which enabled them to work closely with people and to speed their recovery. On-site facilities at the home included a 'health clinic' room, which provided privacy and a professional atmosphere for all visiting healthcare professionals to use. The provider had made an agreement with one GP practice to deliver GP services to the whole home. The agreement included a weekly clinic by the GP at the home, which meant people did not have to wait for an appointment.

Permanent staff were knowledgeable about people's individual medical conditions and were observant to changes in people's moods and behaviours. They made sure people saw their GP to check whether the changes were a symptom of changes in their health. During our inspection, the provider had taken measures to ensure people were referred to healthcare professionals promptly. The acting manager told us the new staff regime they had just implemented would ensure changes were recognised straight away. The revised rotas ensured there was always a permanent member of staff on duty in each household and each household now had a dedicated care coordinator to be a single point of contact for relatives.

Requires Improvement

Is the service caring?

Our findings

People told us they were mostly happy living at the home, because their regular staff were kind and thoughtful. People told us, "They're lovely so that's good", "The night staff are very good with me" and "The staff are great, very supportive." People who lived in the re-ablement household told us all the staff were kind and supportive. We saw most staff smiled at people, spoke to them by name, sat and talked with people and were able to reassure people effectively when they were anxious.

Relatives told us staff were very caring overall. They said, "The permanent staff are caring", "Generally [Name] is well cared for" and "They appear to know the things [Name] prefers." All the people who had moved from the home that had closed for refurbishment, continued to be mostly supported by a consistent group of staff who knew them well. People and relatives were only concerned about the number of irregular agency staff who were allocated to their individual households, because they did not have the time or opportunity to get to know people well enough to understand them.

Relatives told us some agency staff did not demonstrate a caring attitude. They told us, "They don't talk to her. The agency staff could improve their caring attitude" and "The agency staff don't know what she does and doesn't like." During our inspection, we saw that agency staff's skills, abilities and willingness to interact with people were variable.

Staff told us temporary staff who had worked at the home regularly since it opened were 'good workers' who had developed good relationships with people and understood them well. Staff were only concerned with the number of irregular or unknown agency staff who were allocated to a household, without effective oversight from a supervisor or lead care staff. From staff's own evidence, it was clear that when agency staff were needed, they had not always been allocated evenly across the home to ensure there were always sufficient permanent staff on each household to effectively model the provider's caring ethos. By the third day of our inspection, the provider had reviewed and revised the staff rotas to improve how permanent and agency staff were allocated across the home.

The provider had developed systems and technologies to support staff to know people well, but the home registered manager had not consistently ensured staff understood or followed the processes or used the information available to them. For example, people's care plans, including their likes, dislikes and preferences were recorded electronically. This information was available to all staff on hand held devices that they carried with them, but staff we spoke with were not all equally confident in using the electronic records to get to know people well.

Relatives told us they did not know who was the best person to speak with about their relation's care and support. Relatives said, "[Name] should have a keyworker, but we're not told who. There is no single point of contact" and "Is there a buddy or keyworker system? It's really important for [Name] to have a friend to confide in." The provider's guidance for staff to know and understand people well, included appointing care staff as named keyworkers for each person when they moved into the home. Being a keyworker gave staff clearly defined responsibilities for making sure that people's individual personal needs were met according

to their preference. Records for July 2017, showed only 3% of people had been allocated a keyworker. By the end of our inspection visit, the acting manager had allocated keyworkers to 50 of the 63 people who lived at the home.

Improvements were required in maintaining a consistent level of support to enable and empower staff to deliver person centred care. Permanent staff had attended in-house training in the provider's values: 'to play, make someone's day, be there and choose your attitude', which supported staff to get to understand people as individuals. Staff had made pledges about specific actions they would take to deliver person centred care. Follow up conversations were scheduled for six weeks after the training to check whether the training had motivated and empowered staff to deliver person centred care. There was no record to show any follow up meetings had taken place. Staff told us they had not attended any staff meetings or one-to-one meetings where this topic was discussed.

Staff told us they had not felt cared for or supported by the home registered manager or the immediate senior staff during the previous few months. On the first day of our inspection, staff told us, "We don't get any management on the top floor. I don't see anyone. I feel isolated" and "No-one listens." A relative told us, "I feel staff need to be valued and commended. Staff don't look happy. They are doing their best and we don't want staff to leave."

As part of their own investigation, the provider had become aware of staff's feelings of not being cared about, the weekend before our inspection visit started and had appointed an acting manager staff had confidence in. They had worked for the organisation for many years and were well known to most of the staff. On the second day of our inspection visit, staff morale had improved, because they were confident that someone 'cared' about them. Staff told us, "Head office came in on Monday. It is 90% better already (in two days). [Name] will listen" and "[Name] is fantastic, so good. Now there is communication. I was greeted and asked, 'how are you?' I wasn't even acknowledged before the acting manager came."

Requires Improvement

Is the service responsive?

Our findings

Improvements were required in ensuring concerns and complaints were recognised, investigated and responded to promptly. The provider's complaints policy was explained in their service user guide, which was given to people and their relatives when they moved into the home. One person told us, "I complained about someone getting up in the night and making a lot of noise. They asked me if I wanted to make an official complaint. I did and it hasn't happened since." However, several relatives told us they had raised concerns with staff, which were not followed up and said they had not received a satisfactory answer or response. They were not confident their concerns had been escalated appropriately, because there were no identifiable improvements.

Relatives told us they had raised concerns about a lack of feedback about their relation's health needs, about continence supplies and about the lack of visible senior staff, for example. One relative told us, "Three weeks ago I mentioned that [Name] had an infection. I have asked for feedback two or three times. I still don't know whether they were treated for it."

Another relative told us they had asked on numerous occasions since April 2017 for an explanation of why the daily records did not reflect the agreed care plan. They had been repeatedly advised their concerns 'would be investigated', but they not been updated with an outcome of their enquiries, and had not received a satisfactory response. For example, the home registered manager had agreed to update the person's care plan with 'must do' actions for staff, to make sure the person was only offered the food and drinks they had identified at their initial assessment in April 2017 as the person's preference. Records showed their care plan had not been updated with the essential 'must do' actions for staff until 2 June 2017, despite two previous requests for an explanation.

Records showed that the complaints the relative had made through the messaging service and emails had not been recorded as complaints. The first time the relative was listed as a formal complainant was September 2017. Other records we reviewed showed that concerns raised on individual households had not been consistently logged as complaints, so they were not logged, monitored or resolved in accordance with the provider's policy. The home registered manager had analysed the complaints they had logged and had agreed a set of actions to be taken to resolve them. The home registered manger had recorded that improvements in responsiveness would be actioned through handovers and one-to-one conversations with staff. Relatives told us the promised actions, such as ensuring regular named staff were permanently assigned to one unit, had not been sustained.

Records showed the provider had analysed the complaints that were recorded by the home registered manager and taken action to resolve the concerns they had been told about. For example, a member of the senior management team had held a coaching workshop in July 2017 for lead care staff and duty managers to improve their skill at responding to issues and concerns. The home registered manager, in-house senior staff and lead care staff attended the workshop. During the provider's investigation, following a complaint made directly to the provider about how the home was being managed, it was clear that complaints had not been recorded accurately or honestly by the home registered manager. Records showed, for example that

the relative who had raised numerous concerns and complaints about their relation's care since April 2017, was not recorded as a 'complainant' in the complaints log until September 2017.

This was a breach of Regulation 16(1) HSCA (RA) Regulations 2014 Receiving and acting on complaints

The acting manager, was experienced at identifying when issues or concerns should be recorded as complaints. They had previously taken a lead role at senior management level in responding to and resolving complaints. They told us they had already met with all staff and reminded them of the importance of sharing any concerns raised to make sure they were known, appropriately recorded and resolved to the individual's satisfaction.

People and relatives had varied views about the home registered manager's and staff's responsiveness. People who were independently mobile were happy with their support, because they were able to maintain their preferred routines, with support from staff when needed. People told us, "Staff took me down to the hairdressers and to the shop" and "The staff are very supportive. I do most things myself." A member of agency staff told us they were told about people's care plans, mobility and issues about diets, as well as their individual likes and dislikes. They felt confident to respond appropriately to people's needs.

When the home had first opened, people from the home that had closed had been invited to live in the household of their choice. People were able to change their minds if they wanted to. A relative told us, "Initially [Name] was on the first floor, but not with anyone they knew from (the previous home). We had a meeting and asked them to move [Name] to the top floor and they moved [Name] the following week".

The provider had invited all the staff to work at the new home and arranged free transport from the closed home site to Castle Brook for staff and visitors. The bus service runs eight times a day, to take account of staff's various shift patterns, and there are toilet and kitchen facilities available for staff and visitors to use while they wait.

Visitors were welcome at any time. The staff bus service from another town was also free for relatives and visitors to use, to make sure they could continue to visit their relations and friends as easily as before. Visitors were invited to spend time with their relations in the communal lounges and other on-site facilities. There was a café, shop, cinema and launderette on the ground floor, just next to the reception desk. Hot drinks and snacks were available free of charge for visitors.

There was a timetable of regular events and activities that people were invited to attend. People told us, "I run the dominoes club and I can use my laptop. One activity was to the Motor Museum and to the Coventry Air Museum" and "A sheet comes round with the activities. It was alpaca's yesterday." Another person told us they regularly went out downstairs to join the poetry club, art club and to use the two-person bike with one of the home's 'lifestyle coaches'. Care staff knew there were events and activities that took place on the ground floor, but felt that they didn't meet the needs of people who were not inclined to socialise. Staff told us some people who declined to go outside of their 'own-home space' would be more likely to join in if activities took place in their own household.

The provider had implemented an innovative technology, which enabled staff to respond more promptly and appropriately to people's support needs during the night. The system included a listening device that was switched on at night, pre-set to ignore the individual's normal noise level, but to trigger an alarm for unusual noise. The provider had consulted with people and their relatives to explain the benefits of the system and to make sure they agreed with its use. People who did not want to use it, did not have to. The benefit of the system was that staff no longer checked people at night by opening their bedroom doors, with

the common consequence of disturbing them. Instead, people were able to sleep undisturbed, unless they needed support.

The provider had used technology to analyse people's backgrounds, interests and hobbies, dependent on how much information the person or their family had shared at their initial assessment meeting to better match them with other people and staff. This was effective for some people. For example, one person told us, "My room is just next to the kitchen. When I'm hungry I just help myself. They put me in this room especially".

Relatives of people with more complex needs told us the variation of staff's skills and knowledge, and minimal leadership from senior staff, meant they were not confident their relation's needs were understood or responded to when they were not visiting. Relatives told us, "Some have no initiative." We saw staff's skills or willingness to engage with people were variable. For example, we saw a senior member of care staff sat alone at the back of one lounge instead of sitting with people. The same senior member of care staff later walked into the lounge straight past five people to speak with a member of care staff. They did not speak to people on their way in or out of the lounge.

People and relatives had been involved in agreeing the details in their care plans, about how they preferred to be supported and cared for. People's care plans were recorded electronically and care staff updated daily records on their hand-held electronic devices, every time they supported people. The provider was trialling remote access to the daily records for named relatives, either with the person's consent or following a best interest decision. The acting manager told us, "Interactions are recorded on the system with a 'wellbeing' marker in the form of a happy or sad emoticon. Duty managers monitor emotional wellbeing and take action where people are not in wellbeing."

Relatives told us they felt the records of what people ate and drank, and how they spent their time, were not always accurate, which caused them concern. The provider acknowledged the technology was new and they had experienced some issues with data storage and the time of day records were recorded against. The system included a messaging system, where people and relatives could send messages and photos to each other or to the staff.

During our inspection, the acting manager had made immediate improvements to respond to people's changing needs. On the first day of our inspection, staff shared with us that they had been waiting for more than two weeks to hear the outcome of their request for some specific equipment and aids to support people to maintain their independence. On the third day of our inspection they told us, "There have been differences since 12 September. The managers came up. They have ordered two plate guards and two shower chairs for people, because they feel safer with chairs."

Requires Improvement

Is the service well-led?

Our findings

Improvements were required in how the provider monitored the quality of the service. The provider had supported the home registered manager using the same processes, procedures and oversight as they supported registered managers at their other 12 homes. A senior member of the provider's management team, known as a service manager, had visited the service regularly. They checked the home registered manager recorded when they completed the agreed monthly quality and audit checks. When the complaints log had been analysed, 'communication and management' were identified as the commonest causes of complaints. The provider had delivered a workshop training day in June 2017, to coach staff in how to communicate and respond more effectively. The workshop was attended by the home registered manager, assistant manager and seven lead care staff. Relatives and staff's verbal evidence demonstrated that the coaching had not been effective.

The records we reviewed showed that not all the complaints received by the home registered manager had been listed in the complaints log, so they were not available for analysis by the service manager. The records of the monthly meetings that were held for each household were not completed in full, in line with the provider's guidance. Records did not say which staff attended, or whether the home registered manager attended. Actions were recorded as 'planned' in response to changes in people's needs and abilities, but no-one was identified as the person responsible for the action, and there were no dates for when the actions should be completed by. The matrix of needs, which is used to determine staffing levels, had not been completed for two households between May and August 2017.

There was no assurance that the poor record keeping was identified as a cause for concern during the service manager's review of records. The provider's quality assurance process had not identified the extent of poor management of the service or the impact it had on people's perception and experience of the service.

This was a breach of Regulation 17(1) HSCA (RA) Regulations 2014 Good Governance.

When the provider was made aware of concerns about how the service was managed, they took immediate action to investigate and improve the quality of the service. On the second day of our inspection visit we had taken the opportunity to share issues staff had raised with us with the provider and acting manager, where specific people might have been at risk of not having their needs met. The acting manager had taken immediate action to ensure people had the equipment and support they needed, as identified by staff who worked closely with them. The acting manager told us they would schedule review meetings for each person who lived at the home, with their relatives according to the person's preference, to make sure that everyone's needs and abilities were reviewed. They were investigating all allegations of poor care, some of which had not been recorded by lead staff, and said they will let us know the outcome of their investigations.

Improvements were required in the culture of the service. The home registered manager had not consistently demonstrated the provider's values. People, relatives and staff told us the home registered

manager was not consistently open or inclusive and did not empower staff.

The weekend before our unannounced inspection visit, the provider had appointed an acting manager, in response to concerns that had been raised with the chief executive. The first registered manager, who was working as a service manager across a group of homes at the time of our inspection, had their own career development plans that could not be changed. The home registered manager no longer worked at the service by the time our inspection was completed. The acting manager was well-known and trusted by staff and relatives, but they had not had time to change people's, staff's or relatives' views of the quality of the service by the time our inspection was completed.

People who were more independent told us they saw the home registered manager when they used the facilities on the ground floor. One person said, "I see [Name] regularly. They are perfectly approachable. They talk to me." However people who spent time in their own households told us, "The manager has been around a few times" and "I don't think I know who the manager is." Relatives told us they found it hard to talk to the manager as they were 'usually gone' by 5pm and they were not around at weekends.

Relatives told us there was a lack of communication with the whole home management team. Relatives were not confident that the home registered manager had listened to the concerns they raised with staff and duty managers, because they did not get any follow up, feedback or reassurance from the home registered manager. By the end of the first day of our inspection visit, the acting manager had written a letter to people, relatives and staff, to let them know about their appointment. Their letter said they would schedule a formal review of everyone's care and would be speaking with everyone 'as part of that process'.

People's and relatives' views had not been actively sought or heard by the home registered manager. They had not been given the opportunity to talk about how the home was managed, to raise their shared concerns or to make suggestions about their home. People and relatives told us they had not been invited to any home or relatives' meetings since the service opened in December 2016. Some relatives had attended care review meetings, where they discussed any changes to their relation's care and support. One relative said, "They used to have resident and relatives meetings at [former home], but I haven't been told about them here." The provider told us they conducted annual surveys at each of their homes to hear people's views about the service. The service will soon have been opened for one year, so the survey will be due shortly.

Improvements were required in management and leadership. The home registered manager had not understood the responsibilities of being a registered person. They had not always sent statutory notifications to us, in accordance with the legal requirements. When they had made a late referral to the local safeguarding agency, they had said the delay was due to, 'staff being under additional strain with little management support at the time'. They had told the safeguarding agency they would, 'remind staff of the safeguarding adults process' at a team meeting and notify us of the referral. We did not receive a statutory notification about this incident.

Records showed the provider's senior management team had been at the home in the month the incident had occurred, so there was management support at that time. The senior management team visited the home regularly to undertake checks of the documents and records that the home manager kept. There was no record of a team meeting taking place on the day the home registered manager said it would take place.

All the staff we spoke with told us they had not been invited to individual meetings with a line manager to reflect on their practice or discuss their career development. Some staff did not know who their line

manager was. Staff said they had not attended team meetings to talk about the service, only to household meetings, where they talked about individual people's needs. One member of staff told us they had worked at the home for seven months and had not attended any meetings. They said if meetings had taken place, it must have been when they were, "Unable to attend because of the bus."

On the first day of our inspection, before staff had been told an acting manager had been appointed, staff had shared their concerns with us. They told us they felt that the management team did not listen or respond to them in a timely way. One member of staff told us, "We very rarely see a manager in the unit now. [Name] should visit, but they only seem to get in touch when they find something wrong on checking the electronic records system." Other staff said, "I wish they would listen. We used to have meetings. The previous manager was wonderful. Their door was always open" and "We don't get any management on the top floor. You don't feel listened to."

Staff told us they had confidence in the future management of the service after the acting manager had announced their appointment. Staff told us, "Handover is a lot better the last two days", "It was a non-professional management team until two days ago" and "The acting manager is approachable, but I don't know them well yet." Staff told us the acting manager or a provider's service manager had attended every handover since the change in management of the home. Staff said they felt better informed. Staff knew one-to-one supervision meetings had been scheduled, starting the week following our inspection.

People who were more independent were happy with their home and their care and support. Three people told us they could not think of anything to improve. Relatives of people with more complex needs were less happy about the care and support their relations received, because it was inconsistent and staff's skills, particularly agency staff's skills, were variable. Records showed the proportion of permanent staff on duty for the previous 3 weeks varied between 42% and 72%. There was a markedly high proportion of agency staff on duty throughout the week our inspection visit started.

As part of the provider's investigation into how the home was managed, the acting manager had reviewed and revised the staff rota and increased the proportion of permanent to agency staff, on five out of seven days by the following week. They were supported by additional members of the provider's management team to ensure staff were supervised effectively.

As part of their investigation into allegations of poor management of the home, the provider had conducted a full audit of all the medicines in the home, and taken action to make sure there were no residual risks related to medicines. All staff that administered medicines were given clear instructions, support and guidance for quality assuring each other's practice.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not maintained the required practices to ensure safe and proper management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had not followed the local safeguarding arrangements. They had not reported an allegation of abuse to the local safeguarding body promptly, which meant the allegation was not investigated internally or externally.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager had not investigated or taken necessary and proportionate action in response to failures identified by a complainant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and process had not operated effectively to ensure compliance with the requirements of good governance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager had not ensured that all staff received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.