Roseberry Care Centres GB Limited

Alexandra View Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 10 August 2017 and 15 August 2017.

At the last inspection in June 2016 the service was not meeting all of the legal requirements with regard to medicines management and record keeping. At this inspection we found improvements had been made and the service was no longer in breach of these requirements. However, we considered improvements were required with regard to other aspects of people's care.

Alexandra View Care Centre is registered to provide care and support for up to 68 older people, some of whom may be living with dementia or a dementia related condition. At the time of inspection 50 people were using the service.

A registered manager was not in place. 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.

People said they felt safe and they could speak to staff as they were approachable. We had concerns however that there were not enough staff on duty to provide effective and individual care to people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Appropriate training was provided and staff were supervised and supported. Staff had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Although people received a varied and balanced diet we had concerns due to staff deployment and staffing levels people did not all receive prompts and encouragement to eat and drink.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed.

Systems were in place for people to receive their medicines in a safe way. However, we have made a recommendation about the best interest decision making process when people did not have capacity to consent to their medicines.

Changes had been made to the environment. Some areas had been refurbished. However, not all areas of the home were clean and well maintained for the comfort of people who used the service. There were plans that the home would be designed to promote the orientation and independence of people who lived with dementia. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

People said staff were kind and caring. However, we saw staff did not always have time to interact and talk with people. In some parts of the home there was an emphasis from staff on task centred care. We have made a recommendation that staff receive training about person centred care and personhood. Activities and entertainment were available to keep some people engaged and stimulated.

Staff knew the needs of the people they supported to provide individual care. Care was provided with kindness and people's privacy and dignity were respected. Records were not all in place that reflected the care that staff provided.

A complaints procedure was available. People and relatives told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service. People had access to an advocate if required.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to staffing levels, medicines management, nutrition, environmental design and record keeping.

You can see what action we told the provider to take at the back of the full version of the report. One breach with regard to regulation 18 was made because of staffing levels.

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

Not all aspects of the service were safe.

People told us they felt safe. However staffing levels were not sufficient to ensure people were looked after in a safe, effective and person centred way. Staff were appropriately recruited.

Checks were carried out regularly to ensure the building was safe and fit for purpose. A programme of refurbishment was taking place around the home. However, some areas of the home required more immediate attention as they were not clean and they were showing signs of wear and tear.

Staff were aware of different forms of abuse and said they would report any concerns they may have to ensure people were protected.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way. Improvements were being made to ensure the appropriate storage of medicines.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interest decisions were mostly made appropriately on behalf of people, when they were unable to give consent to their care and treatment. However, we have made a recommendation about medicines management.

People received a varied and balanced diet. However, we had concerns that people were not all prompted and encouraged to eat and drink.

Some refurbishment was taking place around the home. Further improvements were planned to ensure it was designed to promote the orientation of people who lived with dementia. We

have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Is the service caring?

Requires Improvement

Some aspects of the service were not always caring.

Staff were caring and mostly respectful. People said the staff team were kind and patient. However, care was task led on the top floor as staff did not always engage with people and interact with them except when they carried out care and support. We have made a recommendation that staff receive training about person centred care and personhood.

Staff were aware of people's backgrounds and personalities. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making. There was a system for people to use if they wanted the support of an advocate.

Records were in place to ensure that people's end of life wishes were respected and carried out.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records did not always reflect the care and support provided by staff. Care plans were in place, but they were not detailed to meet people's care and support requirements.

There were activities and entertainment available for some people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

A full time manager was not in place as the previous manager had recently left and a new manager had not yet been appointed.

The acting management team were introducing changes to improve the quality of care and to ensure the service was well-led for the benefit of people who used the service.

Staff were aware of their rights and their responsibilities to share any concerns about the care provided at the service.

The home had a quality assurance programme to check on the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found during the inspection to ensure people received safe care that met their needs.

Alexandra View Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 10 August 2017 and 15 August 2017 and was unannounced on the first day.

The inspection team consisted of one adult social care inspector and an expert by experience on the first day. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for people who live with dementia. On the second day the inspection team consisted of one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

During the inspection we spoke with 17 people who lived at Alexandra View Care Centre, nine relatives, the area manager, the deputy manager, nine support workers, two registered nurses, three members of catering staff, the hairdresser and one visiting health care professional. We observed care and support in communal areas and looked in the kitchen.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for five staff, five people's medicines

records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One relative commented, "I think [Name] is certainly safe here." However, our observations during the inspection showed there were insufficient numbers of staff available to provide safe, effective and person centred care to people on all floors of the home.

Staffing rosters and observations showed on the top floor 26 people, some of whom lived with severe dementia and over 20 people who were cared for in bed because of their physical care needs, were supported by four support staff and the registered nurse until 2pm, the number of support staff then reduced to three. The majority of people on this floor required two members of staff for their moving and assisting needs and ten people required total assistance. This meant when staff were busy in people's bedrooms, other people had to wait for assistance and people in communal areas were not supervised, when there were only three support workers available. The registered nurse was not able to give assistance routinely as they were busy with other duties such as meeting with visiting professionals, making phone calls and administering medicines.

On the middle floor 17 people were supported by one senior support worker and three support workers. However, one support worker provided one to one care for a person and was not available to support other people. Another person also received one to one support from lunchtime. This meant on the middle floor people did not always receive one to one support when staff were busy as there were insufficient staff to provide one to one care. We observed after lunch on the second day, one support worker was supervising all people who were sitting in the lounge after lunch as well as supposed to be providing one to one support to a person.

On the lower ground floor seven people, were supported by two support workers including one senior support worker. We observed, this floor for most of the first day of inspection only had one staff member as the second staff member was deployed to help in other parts of the home. This meant people were left unattended for much of the day as the support worker was busy.

During the day on the top floor we observed staff did not have time to interact with people apart from when they provided care as they were busy. People were left unattended in communal areas and we observed two people in the dining room on the second day after breakfast, on the top floor were left unattended. One person was asleep at the table, another person was sitting slumped in their wheelchair with a slice of toast protruding from their mouth, a staff member was not present to supervise them.

We observed the lunchtime meal on the three floors of the home. On the top floor we considered improvements were required to staff deployment and staffing levels as the majority of people on this floor were nursed in bed and we observed staff did not have time to monitor and prompt people and encourage them to eat their meal after they had delivered their meal to them. Six people sat in the dining room for lunch and they were left unsupervised for some of the mealtime, after their meal was served we observed they required encouragement and prompts to eat their meal as it was not eaten in some cases. For one

person who was in bed, we intervened and advised the registered nurse the person was having difficulty eating because of the position of the tray and the way the person was lying in bed. For another person we observed they did not eat their food and staff were not available to encourage them to eat. On the first day we intervened and asked the regional manager and deputy manager to come and observe and take action to make improvements to people's dining experience and the organisation of the meal.

We noted on the second day of inspection the improvements that had been made to the top floor dining experience at lunchtime but this needed to be sustained. The lunch time meal was better organised and more staff were available to assist people and lunch was organised in two sittings so people who ate in the dining room were supported first.

As a result of our concerns staffing levels were increased on the top floor and five support workers and one registered nurse were available on the second day of our inspection. After the inspection we were told by the visiting registered manager a staff dependency tool had been used and as a result staffing levels had been increased to the top floor, five support staff and one registered nurse being available in the morning and four support workers and one registered nurse in the afternoon.

However, staffing levels needed to be consistently maintained across the home to ensure people received safe and person centred care at all times with an appropriate dependency tool being used rather than the home being staffed according to the number of people living in the home. Staff meeting minutes had shown as occupancy levels had decreased, staffing levels had been reduced.

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

Not all areas of the home were clean. Some areas of the home were showing signs of wear and tear and there was a mal-odour on the middle floor of the home. We observed the lounge carpet was also marked on this floor and the dining room laminated floor required attention. We were told it had been treated but more work was required. Some communal bathrooms and lavatories also required attention and some bedroom carpets were marked. Some chairs in the communal lounge on the middle floor were also marked. We were aware areas of the home were being refurbished and we were told by the visiting registered manager on the second day that this was being addressed as part of the refurbishment.

At the last inspection we had concerns about the medicines management in the home as there were issues with the storage and disposal of medicines. At this inspection we noted on the first day of inspection all the required improvements had not been made to rectify the breach with regard to the safe storage of medicines. By the second day of the inspection physical work was underway on the premises to convert an office on the ground floor and create an appropriately sized treatment room that could supply adequate storage and refrigeration of medicines.

People were supported with their medicines safely. We were told by the registered nurse one person managed their own medicines. We observed part of a medicines round. A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medicines by placing them in separate compartments according to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the deputy manager. One staff member told us, "I'd report any concerns to the senior." They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. One staff member told us, "I've done local authority safeguarding training." We saw the person in charge made alerts to the local authority and investigated all concerns.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. Relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. At the last inspection we had concerns a system was not in place to check that long standing members of staff were still suitable to be employed after their initial DBS had been carried out. We were informed by the administrator that DBS checks were to be renewed every three years, this was confirmed in the staffing records we looked at. Staff were also asked at their supervision if there was any change in their DBS status. Records of checks with the Nursing and Midwifery Council to check nurses' registration were also available and up to date. Application forms included full employment histories and a copy of each worker's identity was also available.

At the last inspection we had concerns about the maintenance of the building. At this inspection records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, such as the passenger lift, hoists and specialist baths.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was required should the building need to be evacuated in an emergency.

Requires Improvement

Is the service effective?

Our findings

We checked how people's nutritional and hydration needs were met.

Although people's nutrition was monitored we had concerns that staffing levels and staff deployment on the top floor did not ensure that all people were supported, prompted and encouraged to eat their meals or take drinks throughout the day. We observed there was not a protected meal time and there were insufficient staff on the top floor to prompt and encourage people to eat in the dining room and in individual bedrooms where people were being cared for in bed.

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

Records showed people's weight was monitored and this included recording any incidence of weight loss. People were weighed monthly or weekly. The registered nurse told us 19 people on the top floor were weighed weekly and their nutritional intake was monitored because of weight loss. Where people had been identified at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day. For one person, we observed although the fluid level had been totalled it did not record the action that was taken as a result of the monitoring.

Referrals were made to relevant health care professionals, such as, GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause of a person's poor nutritional intake. Records were up to date and showed people at risk of poor nutrition were regularly monitored using a recognised nutritional screening tool. Nutritional care plans were in place to provide guidance to staff. For example, one care plan stated, '[Name] continues to eat finger foods, they need a lot of encouragement. Staff continue to monitor at mealtimes and encourage drinks.' One person told us, "The meals are okay and I've put on weight."

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately.

We observed food was well presented and looked appetising. Portion sizes were generous and people had the opportunity for more. People were offered a cooked breakfast and a choice of main meal was available at each meal. People and relatives were positive about the food saying there was enough to eat. One person told us, "I look forward to a nice breakfast here, the sausage is lovely." Another person commented, "The grub [food] is good." A third person said, "The food is pretty good but not much choice if you are a vegetarian, usually they manage to accommodate me." Other comments included, "Every day there is something different on the menu", "That was nice, I enjoyed that", "The gammon was good, it was nice and tender."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who 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.

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

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. 28 DoLS applications had been authorised by the relevant local authority and others were being applied for.

There was evidence of mental capacity assessments and best interest decisions in people's care plans. Records showed that where people lacked mental capacity to be involved in their own decision making the correct process had been used. However, with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. NICE guidelines state, 'A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.' We were told five people received covert medicine. Records showed that for two of the people signed letters were available from GPs giving their consent but a 'best interest' meeting had not taken place with other relevant people.

We recommend the person in charge considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

The regional manager and deputy manager told us the home was being refurbished. A bar had been created, a new hair dressing salon was also being developed. The lower ground floor and middle floor were well decorated and bright. They had some pictorial displays and pictures to help people engage and be stimulated as they moved around. All floors displayed activities boards and pictorial menus advertising events, activities and meals available each day to keep people informed. We considered the top floor required more attention as it was not 'enabling' to promote people's independence, and involvement. We were told it was to operate as two units, currently people were unable to identify different areas. Signage was not always appropriate for all people to identify the room and to help maintain their independence. Doors such as lavatories and bedrooms were not painted different colours or signed. Memory boxes were not available that contained items and information about people's previous interests to help them identify their room. They would also give staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves. There were no displays, pictures or themed areas of interest on the top floor corridors and no seating areas for people as they moved around. The visiting registered manager told us that the orientation and signage for the top floor was being addressed.

We recommend the service finds out more about current best practice regarding the design of accommodation for people who live with dementia.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as General Practitioners (GPs), psychiatrists, the behavioural

team, speech and language therapy team (SALT) and the dietician. Care plans reflected the advice and guidance provided by external professionals. We observed a newly admitted person was visited by some health care professionals who provided some advice and guidance to the registered nurse, as this had been requested by them.

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. One staff member told us, "We get plenty of training." Another staff member commented, "We do face to face and on line training." A third staff member said, "I do feel supported, I have supervision every two months." Other staff comments included, "We get epilepsy training, it is good information", "There are excellent opportunities for training" and "I had supervision about two months ago."

The staff training records showed and staff told us they received training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people and this included a range of courses such as nutrition and hydration, end of life care, dementia awareness, distressed behaviour, pressure ulcer prevention, care planning and mental capacity. Some staff had also achieved or were studying for a diploma in health and social care at levels two or three.(Previously known as the National Vocational Qualification, NVQ)

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said training consisted of a mixture of face to face and practical training. One staff member told us, "I did practical moving and assisting training when I started." Staff undertook the Skills for Care, Care Certificate to further increase their skills and knowledge in how to support people with their care needs. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of the health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. One staff member told us, "We have handovers from night staff that all staff attend in the mornings." Another member of staff commented, "Communication is good." Relatives told us communication was effective. They were kept informed by the staff about their family member's health and the care they received. One relative told us, "Staff keep us fully informed of [Name]'s care, including flu jabs and other medical appointments."

Requires Improvement

Is the service caring?

Our findings

The atmosphere in the home was calm, friendly and welcoming. People who used the service and relatives we spoke with were positive about the care and support provided. One person told us, "I have everything I want here." Another person said, "I like living here. " A third person commented, "I have a nice room, it's not like being at home though." Other comments included, "The nurses are very nice", "They [staff] have just changed my bedroom and I've got everything I need", "The place is lovely", "It is quiet and you don't get disturbed."

From our observations we considered improvements were needed to the top floor to ensure interaction with people was not task led and that staff engaged with people and not just when they carried out care and support. Staff were busy and did not have the opportunity to engage and interact with each person and encourage their awareness and interest in their surroundings.

We have made a recommendation that staff receive training about person centred care and personhood.

Staff when they had time to engage with people did so in a calm and quiet way. When they carried out tasks with the person they bent down as they talked to them so they were at eye level. Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. One staff member told us, "I know all the residents really well, they are a pleasure to work with."

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Support plans provided detailed information to inform staff how a person communicated. For example, one communication support plan stated, 'Write on the board to communicate with [Name].' Another one recorded, 'Staff to speak slowly and clearly to [Name] maintaining eye contact and always giving them time to respond.'

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person told us, "I love my showers, I can have one whenever I want one, and I get my hair done every Monday." Another person told us, "I have a bit of independence, I can watch television whenever I want, I go to bed and get up when I want." Records also provided information of how people should be supported to maintain their involvement. For example, one support plan documented, '[Name] can choose their own clothes.'

People's privacy and dignity were respected. People told us staff were respectful. We observed that most

people looked clean, tidy and well presented. One person however, on the top floor whose glasses we cleaned, commented, "Thank you so much, they must have been so dirty." We also observed their finger nails were long and dirty. We saw staff ensured any personal care was discussed discretely with each person. A person's care plan also informed staff if people wanted some privacy and time on their own. For example, one care plan stated, '[Name] prefers their own company and enjoys watching television in bed.' Staff meeting minutes showed a dignity champion was appointed from the staff team to promote dignity within the home and to remind staff about aspects of dignity in care.

We observed the lunchtime meal in the three dining rooms. The dining experience was not well organised to the top floor because of staffing levels. In dining rooms the atmosphere was calm and tranquil to encourage people to eat. All tables were set with tablecloths, condiments and napkins. Specialist equipment such as cutlery and plate guards were available to help people, who were able to maintain some independence as they ate their food. People who lived with dementia were encouraged to make a choice or be involved in decision making with regard to their food. Menus were available in pictures for if people no longer recognised the written word.

Information was available in the home about advocacy services and how to contact them. The regional manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Requires Improvement

Is the service responsive?

Our findings

People confirmed they had a choice about getting involved in activities. One person told us, "The activities coordinator takes me out if it's a nice day, or they take me upstairs where we play games with the others." Another person commented, "We have parties, with entertainers and guitarists and the children come from the school and sing." A third person said, "I'm a member of the knitting group."

An enthusiastic activities organiser was employed. They told us they had worked at the home for several years and had attended training courses about activities and dementia awareness. We observed they were passionate and committed. A programme of activities was advertised throughout the home. Activities equipment was available on each floor such as board and floor games and when staff had time they carried out activities with people when the activities organiser was not on duty.

There was a lively atmosphere on the middle floor of the home. To the middle floor we observed people were sitting in communal areas and the dining room in between mealtimes. Staff had some time to engage with people and had meaningful conversations with them. A lively game of skittles took place before lunch on one day and staff were around at this time to support people and talk with them. However, to the top floor and lower ground floor we observed some people remained in their bedrooms or communal areas without stimulation and staff did not have time to spend with them or call in to say hello except when they took meals and carried out tasks with them, as they were so busy. One person who was cared for in bed commented, "I don't do anything, I'm alone with my memories. I would have liked to go out, but it's too late for that now." We discussed this with the regional manager who told us it would be addressed.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people. A relative commented, "We attend an annual meeting, to discuss [Name]'s care." Another relative told us, "It's been two years since the last review meeting that the local authority arrange."

Staff knew the individual care and support needs of people, as they provided the day to day support. Care plans provided some details for staff about how the person's care needs were to be met. However, they were not person centred. They did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence.

Some people had a 'This is Me' profile but it was not available for everyone. The information had been collected with the person and their family and gave details about the person's preferences, interests and previous lifestyle. It is important information to help ensure people receive person centred care and

necessary for when a person can no longer tell staff themselves about their preferences.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour support team or department of psychiatry. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. We observed two visiting professionals who were providing advice and guidance to the registered nurse about a person who had recently been admitted.

We considered records with regard to positive behaviour support needed to be more detailed and person centred. Care plans were in place however, they did not contain detailed information that included what might trigger the distressed behaviour and what staff could do to help de-escalate situations if people became distressed and challenging. For example, a care plan stated, '[Name] refusing personal care….two support staff to assist at all times.' The care plan did not give staff detailed instructions with regard to supporting the person. Information was not available that included what might trigger the distressed behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce the anxiety and distressed behaviour.

We were told by the regional manager and visiting registered manager that a new care planning system was being introduced and staff were to receive training about person centred care. This would help to ensure all people received care in the way they wanted and needed when they were unable to tell staff themselves.

Meetings were held with people who used the service and their relatives. The deputy manager told us they had not taken place since the manager left but they were planned to keep people up to date with any changes in the service.

People knew how to complain. People we spoke with said they had no complaints. A relative commented, "I know who to speak to if I had any complaints." Another told us "I'm not sure who the manager is now but I'd knock on the office door." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in place, as the previous registered manager had recently left in July 2017 and a new manager had not yet been appointed. Arrangements were not in place for a designated manager to be responsible for the day to day running of the home. We were told the regional manager was available at the home two days of the week and the deputy manager, who had been appointed in April 2017 was acting as the manager. However, they were also one of the registered nurses and did not have full supernumerary hours to be responsible for the day to day management as they worked as a nurse.

We considered that due to the issues highlighted and the history of the home a manager with dedicated management hours should be available as the acting manager was also running the home as well as carrying out nursing duties. We observed on the first day of inspection when staff members requested some guidance they were passed between the deputy manager and registered nurse as both were busy.

We were informed after the inspection that a manager had been appointed to begin work at the home on 9 October 2017. The deputy manager had also been provided with more supernumerary hours to be responsible for managing the home.

The deputy manager, regional manager and visiting registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The regional manager was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The atmosphere in the home was lively and friendly. Staff were positive about other staff in the home and had respect for them. One staff member commented, "I love working here." Several staff members told us they had worked at the home for several years. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. One staff member told us, "The regional manager is very approachable." A relative commented, "Staff in the office are approachable."

Staff told us monthly staff meetings took place and minutes of meetings were available for staff who were unable to attend. One staff member commented, "Staff meetings keep us up to date with what's happening in the home." Another member of staff told us, "Staff meetings happen monthly." Staff meeting minutes showed topics discussed included training, person centred care, care planning, staff performance, complaints and incident reporting. Staff meetings kept staff updated with any changes in the service and to discuss any issues.

The regional manager said changes were being introduced to the home to help its smooth running and to help ensure it was well-led for the benefit of people who used the service. Meeting minutes also showed that the ethos of the home was that it was to be run for the benefit of the people who lived there rather than the staff who worked there. After the inspection the director of operations also assured CQC of changes that were being implemented.

At the last inspection we had identified that robust systems were not in place to evaluate accidents and incidents and audits that were carried out in the home. At this inspection we saw some improvements had been made.

Records showed regular analysis of incidents and accidents took place. Learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to distressed behaviour and people who may be at risk of falls. The deputy manager told us with regard to falls a tool had been developed on the computer for falls analysis and the each fall was entered as well as the incident form being analysed. Records showed people were referred to the relevant professional for advice and guidance when a certain amount of incidents were recorded.

Auditing and governance processes were becoming more robust within the home to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A monthly risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the home and passed to head office for analysis.

The deputy manager told us monthly audits were carried out and the results were signed off by the regional manager. Monthly audits included checks on care documentation, staff training, medicines management, home presentation, complaints management, health and safety and accidents and incidents. Other audits included health and safety and infection control. However, the audit and governance processes had failed to identify deficits as identified at our inspection.

Records showed monthly visits were carried out by the regional manager to speak to people and the staff regarding the standards in the home. Reports showed they also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, social activities, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Action plans were produced from monthly visits with timescales for action where deficits were identified. Recent reports showed the improvements that had been made to help ensure the service was run for the benefit of people who lived in the home and to ensure they were safe and comfortable.

The provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and relatives. Survey results were not available at the time of this inspection from the last quality assurance audit due to the changes in management.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staffing levels were sufficient to ensure that people received safe, effective and person centred care. Regulation 18 (1)