Enhanced Elderly Care Limited

Enhanced Elderly Care Service - Wardley Gate 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 carried out on 17, 20 and 25 January 2017.

Wardleygate Elderly Care Service provides accommodation and personal care to a maximum of 88 older people, including people who live with dementia or dementia related conditions. At the time of inspection 75 people were living at the home. Nursing care is not provided.

We last inspected Enhanced Elderly Care Service Wardleygate in January 2016. At that inspection we found the service was not meeting all its legal requirements with regard to staffing levels, meeting people's nutritional needs, respecting people's dignity, records and governance. At this inspection we found that sufficient action had not been taken in all the required areas to make sure the relevant legal requirements were met.

A registered manager was not in place. The previous registered manager had left in December 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection some improvements had been made, however efforts were needed to improve the care and experiences of people who lived at the home. People enjoyed a better dining experience, although this could still be improved. Some improvements had been made with regard to record keeping to ensure people received person centred care. People's dignity was respected. Improvements had been made to menus and the choice of food available. However, systems needed to be improved to support and monitor people at risk of poor nutrition and weight loss.

People told us they felt safe. However, staffing levels were not sufficient to ensure people's needs were managed safely and in a person centred way at all times. Staffing levels were in the process of being increased as the result of our inspections but they needed to be consistently maintained. We saw staff did not always have time to interact and talk with people. There was an emphasis on supervision and task centred care.

A programme of activities was available but activities provision was not well-organised around the home so people had an opportunity to take part. Staff did not have time to carry out activities when the activities people were not available. We have made a recommendation about activities to ensure people remain engaged and stimulated.

Systems were in place or being introduced for managing and mitigating risk. A more critical accident and incident analysis was introduced. This needed to be maintained and regularly reviewed to identify any

trends of accidents and incidents that occurred to help prevent them occurring.

Risk assessments were in place but they did not all accurately identify current risks to all people. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People received their medicines in a safe and timely way.

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. We have made a recommendation with regard to communication to ensure all the required information is passed on to staff about people's health and well-being.

Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were respected. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves.

Staff received opportunities for training to meet people's care needs and in a safe way. A system was in place for staff to receive supervision and appraisal but not all supervisions were up to date due to the management changes.

A complaints procedure was available. Improvements were required to any complaints received to ensure they were dealt with according to the home's complaints procedure.

People told us the current management team and staff were approachable. They told us they were asked their views about the service they received. A quality assurance system was in place but it needed to be more robust. The audits used to assess the quality of the service provided were not effective as they had not identified the issues that we found during the inspection.

Full information about the Care Quality Commission's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

You can see the action we took with regard to the non-compliance with aspects of nutrition and complaints at the back of the full 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

Not all aspects of the service were safe.

Although people told us they felt safe we found systems were not in place to ensure their safety and well-being at all times. There were not sufficient staff and they were not always appropriately deployed to provide individual care to people. There were systems to ensure that new staff were suitable to work with vulnerable adults.

Risk assessments required more regular review to ensure they reflected any current risks to people.

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

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were supported to carry out their roles and received the training they needed.

We have made a recommendation to improve communication. This was to ensure the necessary information was passed between staff to make sure people received appropriate care.

Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Improvements had been made to menus and choice of food. However, a more robust system was required to ensure people who were at risk of losing weight were appropriately monitored.

Is the service caring?

Requires Improvement

Most aspects of the service were caring.

Staff were kind and caring but there was an emphasis on task centred care as staff were busy and did not spend time talking with people or engaging with them.

We found people were helped to make choices and to be involved in daily decision making. However their meal time experience needed some improvement.

There was a system for people to use if they wanted the support of an advocate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some improvements had been made to record keeping. More improvements were required to ensure people received support in the way they wanted and needed.

People were provided with some activities. We have made a recommendation with regard to activities to ensure people have more stimulation. People had the opportunity to access the local community.

People had information to help them complain. Complaints were mostly recorded but information was not always available to show the action taken where a complaint had been received.

Is the service well-led?

Requires Improvement

The service was not well-led.

A registered manager was not in place who was registered with the Care Quality Commission. A management team were in place to make improvements and an acting manager had been appointed.

Improvements required from the last inspection had not taken place in a timely way or had not been sustained to ensure people received safe and individual care.

Staff and relatives told us the management team were supportive and could be approached at any time for advice and information.

A quality assurance system was in place but it needed strengthening. The systems used to assess the quality of the service had not identified the issues that we found during the inspection. Therefore the quality assurance

processes were not effective as they had not ensured that people received safe care that met their needs.

We have made a recommendation that the results of the provider's surveys and any required actions are advertised. This will show what the service does well and any action that has been taken, if required as a result of people's responses.

Enhanced Elderly Care Service - Wardley Gate 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.

This inspection took place on 17, 20 & 25 January 2017 and was unannounced. The inspection team consisted of one adult social care inspector and two experts by experience on the first day, two adult social care inspectors and two experts by experience on the second day and three adult social care inspectors on the third 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.

Before the inspection we reviewed 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. We spoke with the local safeguarding teams.

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.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 43 people who lived at Enhanced Elderly Care Service Wardleygate, 23 relatives, the provider's nominated individual, the operations director, the acting manager, the deputy manager, one unit leader, 15 support workers including four senior support workers, the activities co-ordinator and two members of catering staff. 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 18 people, recruitment, training and induction records for ten staff, nine 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

At the last inspection there was a breach of regulation 18(1) with regard to staffing. We had found that staffing levels were not sufficient to meet people's needs in a safe and timely way and to ensure they received the care they required.

At this inspection we found staffing levels had not been increased in a timely manner or maintained across all floors of the home. This was needed to ensure that people received safe and individual care and support. We were told staffing levels were determined by the numbers and needs of people using the service and were calculated using a dependency tool. Our observations during the day and peoples' comments did not show that sufficient staff were available to supervise people and attend to them in a timely way.

We were told there were 70 people living at the home at the time of inspection. Staffing rosters and observations showed on the top floor 10 people, some of whom required two staff members to assist them because of their physical dependency were supported by two support workers and a unit manager. On the middle floor 30 people some who lived with severe dementia and needed full staff support for all their needs were supported by six support workers including one senior support worker. On the first day of inspection we observed only five staff were available on the middle floor at 10:00am. We were told staff were absent and arrangements were being made to get additional staff to come on duty. Later in the morning two extra support workers came on duty. To the ground floor 30 people, several who required two members of staff for their moving and assisting needs, were supported by one unit manager and four support workers including a senior support worker. We noted these staffing levels had not increased since the previous inspection and there were still not enough staff available at all times to meet people's needs in an individual, safe and timely way.

Overnight staffing levels included eight staff, a senior support worker and two support workers to the ground and middle floor and one support worker and one senior support worker to the top floor.

Comments from people who used the service, relatives and staff corroborated our findings. Peoples' comments included, "They could do with more staff", "Staff are lovely but there aren't many of them", "I have no problem with any of the staff –they could use a few more I think", "Sometimes the staff take a while to answer and are always very busy", "Carers don't have time to talk they are too busy", "Staff are too busy, they pop in when they can", "Staff are fantastic but they're overworked and understaffed", "I think they need more staff. They said they were working on it but I've seen no change." Other people told us, "One tea time the carer was alone and answering buzzers and serving teas, they were run off their feet", "They seem to need more staff, we have had many issues" , "A carer said they can't answer all the buzzers as they're only a human being" and "The girls are good, they look after you, but they need more staff so we can get the care we need."

Staff comments included, "We do our best, it's the lack of staff", "There's not usually enough staff on the ground floor, especially when people phone in sick", "You have to make people wait and they can have an

'accident' which does not promote their dignity", "Mornings and lunchtime are the busiest", "I like my job but I'm very stressed out as we need more help", "There aren't enough staff in so I have to help here so I can't give out the medicines." Some other staff told us, "The manager has called people and asked them to come in, but couldn't get anyone to come in, so what can you do-they tried", "I get stressed as there's so much to do and everyone wants to go back to their room straight away after lunch and we just can't do it", "I enjoy my job but it is so stressful sometimes due to lack of staff" and "Staff call in sick a lot."

Relatives' comments included, "The home needs more staff", "There is not enough male staff or staff overall-they really do need more", "The staff are excellent here but there are just not enough staff at all", "The general care from staff is good, but they are overworked, especially when they are short staffed", "Staffing levels can be a problem" and "More staff are needed."

The operations director told us more staff had been recruited and it was planned to have an additional staff member from 5:00pm-11:00pm and at other peak times of day. However, we considered this should have been addressed since the last inspection in January in a more timely way by the provider. We are taking action outside of this report with regard to staffing levels to ensure sufficient staff are made available to care for people in a safe, timely way that respects their dignity.

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

Before the inspection we had received some complaints about the use of the nurse call system and its inaccessibility for people in communal areas and it not always being available in their bedrooms. We had discussed with the operations director the use of portable nurse call fobs to be made available in communal areas for people who needed to call for staff assistance. These were made available but we observed during the inspection they were not always accessible to people in communal areas to call for assistance if staff support was needed. We observed in the top floor lounge and dining room no call alarm devices or pendants were available for people. On the ground floor three pendants were available but they were placed on a coffee table one day out of reach of people and on the fire place another day, again out of reach of people. We observed people who chose to remain in their bedroom were able to access the nurse call in their room to summon for staff assistance as the buzzer was placed within their reach. We discussed with the operations director the need for a regular check to be carried out to ensure the nurse call was plugged in and accessible to each person whilst in their bedroom or in the communal area in case they needed to call for staff support. We also discussed a regular weekly check to ensure each nurse call was working. We were told a weekly check was done but we did not have sight of audits to show the weekly test carried out to show the nurse call system was working.

Individual risk assessments were in place but the system of review to ensure they remained relevant, reduced risk and kept people safe was inconsistent. The risk assessments included risks specific to the person such as for moving and assisting, mobility, nutrition and pressure area care. The monthly evaluations included information about the person's current situation. However, records showed some risk assessments for falls, moving and assisting and nutrition had not been reviewed since August 2016. Regular review was important to ensure they reflected any current risk to a person.

We noted nine incidents where people had fallen and broken a limb between February and December 2016. Some people told us about their falls. Their comments included, "I've had several falls", "I fell the other day. I have a pressure mat but no one came, I shouted for help", "I fell one night getting into bed and I couldn't reach the buzzer." Their relative told us the person now has two support workers in their care plan, to assist the person when moving. One relative told us, "[Name] has had lots of falls since being here" and another

relative commented "When we visit sometimes [Name]'s pressure mat is not beside their bed." We discussed with the management team the arrangements that were in place to keep people safe. We were told incidents were analysed by the management team at the home and head office. The analysis included time of incident, place, and staff deployment at the time. Measures were in place to reduce the likelihood of these incidents occurring and to make sure any learning from incidents took place with staff. Staff meeting minutes showed falls were discussed with the staff team. Arrangements were in place, such as the use of sensor mats to alert staff when people who had been assessed as being at high risk of falling, may be trying to move without support. Where several falls had taken place a person was referred to the falls clinic.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. This was for if the building needed to be evacuated in an emergency. The plans had been completed when people moved into the home. However, a regular system of review was not in place to ensure plans were kept up to date and accurately reflected the people needed in the event of an emergency.

Most people we spoke with told us they felt safe at the home. Their comments included "I feel very safe here", "I feel safe I don't feel afraid or anything like that", "I am safe in here as I'm not on my own", "I'm safe and happy as here as people are around", "I feel safe and secure here. I have no worries" and "I do feel very safe in here." Relatives' comments included, "I feel it is totally safe for [Name]. I have no concerns with that", "I think [Name] feels very safe here and that's what matters." Staff we spoke with were clear about the procedures they would follow should they suspect abuse. They expressed confidence that the management team would respond to and address any concerns appropriately. All of the staff spoken with told us they had been trained in safeguarding and this was confirmed by training records. There were also safeguarding procedures and guidance available for staff to refer to. This provided appropriate explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The management team were aware of when they needed to report concerns to the local safeguarding adults' team. Safeguarding alerts had been raised promptly. They were investigated and resolved to ensure people were protected.

People received their medicines in a safe way. We observed part of the medicines rounds on two floors of the home. We saw staff who administered medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. They explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. Medicines were given as prescribed and at the correct time. Staff members told us medicines would be given outside of the normal medicines round time if the medicine was required for example, for pain relief.

Most medicines were appropriately stored and secured and this included the arrangements for controlled drugs, which are medicines which may be at risk of misuse. However, one bottle of a liquid controlled drug which had been opened was past its use by date. We were told night staff audited medicines. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Application forms included full employment histories. Applicants had signed their application forms to

confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records 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 checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, 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, for example, the passenger lift, hoists and specialist baths.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found a breach of regulation 14 with regard to people's nutrition. Improvements were required with regard to the ordering of food and management of menus to ensure people were satisfied with their food.

At this inspection we saw some improvements had been made and people were more positive about the quality and variety of food. The provider had taken action that included regular surveys with people to collect their comments about the food. The operations director sampled the food to test the quality before it was served to people and kitchen staff served the food in the dining rooms to collect feedback from people about the meals. Menus were also an agenda item at meetings with people who lived at the home and relatives.

Peoples' comments to us included, "The lunch was lovely", "The food is very good, its excellent, there's a lot of it though", "The menus have improved", "The food is very bland", "The food is poorly made, the sandwiches aren't filled very well and they end up not being eaten", "The food is okay, we get a choice. If there was something I really wanted I'm sure they'd make it for me" ,"Food is good, I feel there is enough choice for me and portion size is good" and "Food is okay, I enjoy breakfast." Relatives' comments included "[Name] seems happy with the food, it looks appetising", "and I feel [Name] enjoys the food here, they have always had a good appetite and "That lunch was lovely."

At this inspection we had concerns with some other aspects of people's nutrition and hydration. Robust systems were not in place to monitor weights for people including those people who may be at risk of poor nutrition and subsequent weight loss. Nutritional care plans were not in place as required for some people and those in place did not always accurately reflect the specialist support requirements needed. Food and fluid charts for monitoring intake, did not accurately reflect the amounts people had eaten for monitoring purposes.

This was a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff were positive about the opportunities for training to understand people's care and support needs. They told us they were kept up to date with training and that training was appropriate. Staff comments included, "I get the training that's needed, it's a nice home", "I've had plenty of moving and assisting training….it's very good" and "I think we have the training we need to meet people's needs."

The staff training records showed and staff told us they had received training to meet people's 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. The training gave staff some knowledge and insight into people's needs and this included a range of courses such as dementia care, equality and diversity, nutrition, skin care and end of life care.

Staff told us and their training files showed they received supervision from the management team, to discuss their work performance and training needs. However, staff records showed not all supervisions were up to date. One staff member told us, "Supervisions offer the opportunity to raise concerns. We're asked how things are going."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. One person commented "I see a dentist and chiropodist regularly and I've just had my eyes tested as well." Staff received advice and guidance when needed from specialists such as the community nurse, physiotherapist and dietician. People's care records showed they had regular input from a range of health professionals such as General Practitioners (GPs), behavioural team, psychiatrists, a speech and language team (SALT) and psychiatrists. Records were kept of visits and care plans reflected the advice and guidance provided by external professionals.

Relatives told us they were kept informed by the staff about their family member's health and the care they received. One relative told us, "Staff always call and let us know if there any changes to discuss. They are great with this."

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. There was also a handover record that provided some information about people, as well as the daily care entries in people's individual records. The handover record did not provide detail of people's mood and well-being. it described for example someone as 'settled.'

We have made a recommendation to improve communication. We considered the handover record required more detail to provide prompts to inform staff coming on duty about the current state of people's well-being. This was so information was communicated so staff were aware of risks and the current state of health and well-being of people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. The acting manager and staff were aware of the deprivation of liberty safeguards and knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. We found as a result, that 39 people were currently subject to such restrictions.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

Requires Improvement

Is the service caring?

Our findings

Staff appeared to have a good relationship with people and knew their relatives as well. The majority of people and relatives we spoke with said staff were kind, caring and patient. People's comments included, "I love my room, I feel at home here", "Staff are nice and caring but there is not that many of them", "It's a happy place, no problems", "Staff are patient enough. If I ask for something they will help", "Staff are fine and around when I need them", "Staff are quite alright here", "You can't fault the staff here, they are lovely- but they really need more", and "I get on well with all the staff." Relatives' comments included "Staff are lovely but I think everyone would agree they are completely run ragged all the time", "Staff are excellent and I have a great rapport with them", "Some staff are good and some just don't want to be here", "Some staff are good to be honest and some are not. Sometimes the way they speak to people is not good. I feel they don't put themselves out or consider much", "I'm generally happy with the care" and "Some staff are patient and kind but some have to be told to do something, but they should know their job really."

We saw staff were busy and did not have the time to talk to people and spend time listening to what they had to say. We observed many staff only engaged and interacted with people when they were carrying out a task with a person. For example, when they offered people a drink, or when they helped people to mobilise. For some people, we noted the conversation was only to give instructions. We saw people sat sleeping in lounges for much of the time. Those people who were able to communicate verbally received a little more interaction from staff, as they engaged with them for their attention. When staff were available, they sat in a corner of the room at a table completing records. We saw care was task centred rather than person centred. This meant support workers carried out tasks with people rather than attending to them at a time they may choose and spending time sitting interacting with them. Staff told us they were kept busy and did not have time to sit with people. They said, in the afternoons there maybe a little more time, as mornings were very busy. They said they needed to complete the charts to show what care they carried out with the person.

By day three of the inspection we observed staff on the first floor had more time to spend with people and engage with them. We observed the improvements to people's care and mood because staff were enthusiastic and had time to spend talking with them about things that interested them, interacting with them on an individual basis. They were kind and caring and they sat amongst people engaging with them and not only supervising them. One person who displayed behaviour classed as challenging benefited from the staff time and interaction and this reduced their distressed behaviour as they were engaged in an activity.

We observed the breakfast and lunch time meals on the three floors during the course of the inspection. The dining experience on the ground and first floors was not well organised. The meal time organisation showed it was not an event that encouraged people who had problems with nutrition to eat well as they had to wait. It was also difficult for staff to monitor people's food intake. At breakfast on the first day on the first floor the support worker was busy as they served the meal and supervised people to eat in the first floor dining room. We observed as only one dining room was open for breakfast there was insufficient seating for people, with not enough tables to accommodate the 30 people who may require breakfast. We also observed the

breakfast time meal on the first floor continued until after 11:15am when the lunch time meal was served at 12:30pm. On our second day it was better organised as some extra tables had been set in the hallway to accommodate people so they were not waiting and milling around as they waited for breakfast.

Lunchtime was better organised across the home. Two dining rooms were available for people to use on the first floor and catering staff served meals in all dining rooms so support staff were available to provide assistance to people. When staff carried out tasks with the person they bent down as they talked to them so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. For example, one staff member talked gently to a person as they supported them to the table for lunch asking them, "Are you ready to come to the table?" Another worker asked, "Where would you like would to sit? You can sit anywhere you like." Staff provided prompts of encouragement in a quiet and unhurried way, for example, "Are you going to try and eat something, here's your spoon." We observed however after the lunch time meal on the ground floor some people had to wait some time to leave the table and return to their room as staff were busy. We observed people had to remain sitting at the dining table until after 2:00pm as other staff were not available to support them to their bedrooms or communal areas. We judged that this needed to be addressed with increased staffing levels so more staff were available to support people in a timely manner.

A menu was available on the wall but some people were not aware of what they were having to eat until the meal time. People were offered a choice and people who may no longer understand the written word were shown two plates of food so they could smell and see the options available. We saw if people did not want the available food an alternative would be prepared. However, a person would have to wait as the chef was not always informed before the meal, meaning the alternative was not served at the same time as other people received their meal. The chef told us the arrangement was that staff were supposed to notify the catering staff by 11:00am, so the alternative could be prepared, however we were told this did not always happen.

People told us their privacy and dignity were respected. People's care plans recorded their preference for gender of carer to carry out any aspects of personal care with them. Staff advised us any curtains were drawn or doors closed for privacy and dignity. We observed staff members always knocked and waited for permission before entering a person's bedroom. For example, a staff member asked "Is it alright if I come in. One person commented, "Staff treat me with respect and dignity."

Staff were patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks. Peoples' care plans contained detail of how staff were to support people. Communication care plans were available for some people that detailed how they may show or indicate their choices and how staff could keep them involved if they did not communicate verbally For example, one care plan stated, '[Name] speaks in a whisper. Staff are to speak loud and clear and [Name] will respond with a yes or no answer.' Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing people options to help them make a choice such as two items of clothing. Records also contained information to help staff promote choice. For example, one care plan for personal hygiene stated 'Staff to promote choice and independence when choosing clothing.' This encouraged the person to maintain some involvement and control in their care.

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. Care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told this was discussed and the relevant people were involved in the decision making to inform staff of the person's

wishes at this important time and to ensure their final wishes could be met.

The service supported people to access advocacy services where needed. Some people were supported by an Independent Mental Health Advocate (IMHA) because they lacked the mental capacity to make decisions with regard to their well-being. Advocates can represent the views for people who are not able to express their wishes. Information was displayed that advertised what advocacy was and how the service could be accessed.

Requires Improvement

Is the service responsive?

Our findings

We received mixed reviews about activity provision. Peoples' comments included "There's definitely things going on. If you come on the wrong day you might think there's not", "Taichi (exercise to music) is popular", "It's boring here, can't go anywhere", "I'd love to go somewhere interesting like a museum", "I go to the exercise class and trips out", "There's not much entertainment but I go out on the bus occasionally", "It would be great if we could go out, we never go anywhere, "They've put planters on each balcony so we can garden", "I don't really join in the activities I much prefer to sit here in my room", "I would go anywhere really for day trips, a shopping trip or even just to chat to different people", "I'd like to take part in activities but I don't know what's going on", "I just sit here and enjoy the television", "There are lots of activities", "I would love to go out somewhere" and "I play dominoes and pool during the week."

A programme of activities was available and activities included armchair exercises, baking, quizzes, pamper sessions, gardening, film afternoons, arts and craft, music, reminiscence, bingo, men and women's club, choir, board games, cards and quizzes. Individual records showed the activities that people took part in supported by the activities staff. One person told us, "I enjoy gardening and helped with planting the garden boxes." The hairdresser visited weekly and a regular church service also took place. Entertainment and concerts also took place. We saw a variety of seasonal entertainment had been arranged for over the Christmas period including a party, a visit from a local school choir and entertainers. A newsletter advertised seasonal and fundraising events to raise funds for activities and outings. A relative told us," The activities coordinator is a breath of fresh air" and another relative commented, "The activity coordinator is nice they always try to include my family member." The home had access to a mini bus and people had the opportunity to go out in small groups.

Although activities were available some of the activities provided did not benefit many people who lived in the home. Two activities staff were available to provide activities for people. However, we observed they did not appear to be effectively deployed to ensure that the activities were available to the maximum number of people if they wished to take part. For example, three people were engaged in a baking session. Across the home because staff were busy and did not have time to interact, many people sat unoccupied. We were told, "When [Name] takes people out it means there is nothing going on here in the home for others as staff are busy as they're short staffed." By day three of the inspection activities provision had increased. Tai chi took place on the first floor, this was exercises to music and it was noticeable the calming and engaging effect this had on some people who lived with dementia. People who had previously sat disengaged or sleeping took part in the exercises and followed the instructions and visual prompts of the visiting person who carried out the activity. People looked stimulated and alert. Musical entertainment was also taking place that all people could attend if they wished.

We recommend the home expands the programme of activities to ensure people who live with more severe dementia are kept stimulated and engaged. Staff to continue with activities provision with all people when an activities person is not available.

At the last inspection we had found a breach of regulation 17 as records did not accurately reflect the care that people received to ensure they received person-centred care.

At this inspection we found some improvements had been made and records provided more detail and information about people's care and support. This information helped staff support the person in the way they wanted. It included detail if they were unable to communicate their wishes verbally to staff. However, we found some improvements were still required as record keeping was inconsistent.

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 in most cases monthly reviews of assessments and care plans took place. However, we saw not all records had been reviewed and they did not all reflect the changes that had taken place to provide an accurate account of people's progress and well-being. The operations director told us that all care records were being transferred to an electronic system and this would help improve record keeping as the system would flag up if a record had not been reviewed. This would help ensure records reflected the care provided by staff. It would also ensure all staff had access to read people's care plans. We had been told by support staff they did not have access to people's care plans. Rather they were informed verbally by senior staff about people's care and support needs and any changes in those needs.

Other information was available in people's care records to help staff provide individual care and support. For example, a sleep care plan stated, '[Name] likes to go to bed between 20:00 and 21:00 and will have a cup of tea and a snack before retiring to bed." A care plan for a person who did not communicate verbally stated, '[Name] enjoys when staff massage their hands and applies hand cream.' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's records contained personal profiles that were personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Some were more detailed than others. Examples included, '[Name] likes music and dancing', and 'I love to read so I usually go to bed quite late. The staff are okay with that. Medicines care plans detailed how people wished to receive their medicines. One example stated, '[Name] likes to take their medicine one at a time from a spoon swallowing down with water.' Staff told us they observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. However, a written record was not available to inform staff who did not know people so well the signs to identify if someone was in pain and how they may communicate their pain and distress.

Records were in place for the management of behaviours described as challenging. Some care plans gave staff instructions with regard to supporting people if they became agitated or distressed, with details of what might trigger the distressed behaviour and what staff could do to support the person. This guidance helped ensure staff worked in a consistent way with the person, to help reduce their anxiety and distressed behaviour. However, some care plans did not detail what might trigger the distressed behaviour and what staff could do to distract the person. One care plan mentioned the use of 'when required' medicine if it was needed. However, it did not provide guidance to instruct staff at what stage the medicine should be

administered to reduce the person's distress and to ensure it was administered as a last resort.

Records showed if there were any concerns about a change in a person's behaviour, a referral would be made to the department of psychiatry of old age and the behavioural team. Staff told us they followed the instructions and guidance of the behavioural team for example, to complete behavioural and observation charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

Regular meetings were held with people who used the service and their relatives. Meeting minutes showed items discussed included, 'activities and outings, menus, communication, laundry and social media.' Separate meetings also took place with people who used the service and meeting minutes showed people were asked about activities, laundry and food.

People using the service and their relatives told us they knew how to complain if they ever needed to. Most said they would speak to the manager or a senior member of staff if they had any concerns. Peoples' comments included, "I have never had a complaint" and "I have no major complaints." Relatives commented, "I tend to go to one of the line managers if I have any problems and they sort it out", "I did have a couple of issues. So I spoke to this line manager and this was resolved. Without this person, I don't know what we would do", "If I did need to speak to anyone or a manager here I would have no problem doing so", "I haven't raised any complaints as such but I would talk to someone if I needed to" and "The staff are lovely here, no complaints."

We had concerns all complaints were not appropriately dealt with.

A copy of the complaints procedure was clearly available in a public space and in people's bedrooms. We reviewed the records of the four complaints received by the home in 2016, which mainly related to poor personal care, social isolation and weight loss. We noted these did not include the complaints received by the Care Quality Commission and passed to the home to investigate. There was some evidence that showed the action was taken to address the concerns but this was inconsistent. The complaints file did not contain details to show what action was taken, including any remedial action. There was no acknowledgement or outcome letter for the complaint with an apology if appropriate. This meant it was difficult to trace that all people were listened to and their concerns acted upon.

This was a breach of Regulation 16 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At the time of inspection a manager had not been appointed as the previous registered manager had very recently left. The day to day management of the home was being carried out by the provider's representative and the operations director who were located in the building to oversee improvements and the management of the service. The operations director informed us during the course of the inspection that an acting manager had been appointed to oversee the day to day running of the home.

We found that the breaches of regulations and areas for improvement identified at the last inspection had not all been acted upon and rectified by the provider's management team. The findings from this inspection were that the service was still in breach with regard to staffing levels and good governance. We therefore had concerns the service was not consistently well-led to ensure good and quality outcomes for people who used the service. We are taking action outside of this report with regard to governance to ensure the provider's quality assurance system ensures quality outcomes for people who use the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Measures were now being taken by the provider to make improvements although timely action had not been taken since the last inspection to rectify the breaches. Staffing levels were being increased but they needed to be consistently maintained to ensure the safety and individualised care of people who used the service. The quality of record keeping needed to improve but we considered some of the remaining deficits would be removed with the introduction of the electronic document system. This would be available for all support and senior staff to use to ensure people received care appropriate to their needs.

We had concerns the audit and governance processes had failed to identify deficits in certain aspects of the running of the home. For example, a system to ensure safe staffing levels were maintained including to replace any absent staff in a timely way, ensuring staff supervision took place regularly, the nurse call system to keep people safe, people's dining experience, record keeping, communication, some aspects of care provision and activities.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on health and safety, documentation, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. However, although records were audited monthly and included checks on care documentation and staff management, these audits had not highlighted deficits in certain aspects of record keeping. This included care planning, the regular review of peeps to ensure people could

be safely evacuated from the building in the event of an emergency, social profiles and risk assessments to ensure they contained accurate and detailed information so people received safe care in the way they wanted and needed. The audits had not highlighted the inadequate staffing levels despite the findings of the last inspection and comments from staff, relatives and people who used the service.

We were aware that there was some external scrutiny of the governance and auditing that took place in the home. This included the weekly reporting of accidents and incidents, complaints, safeguarding to head office for analysis and visits by the providers representatives. We considered external governance needed to become more robust. We were told compliance officers had been employed to provide oversight over all the provider's locations, to provide scrutiny and ensure the required audits were taking place and that they were effective.

Audits were carried out for health and safety, medicines management, laundry and maintenance of the environment, however not all areas that were audited were overseen by management. For example, we were told medicines were audited by night staff but there was no evidence of action taken from the audit. We were told monthly visits were carried out by the operations director to check on the quality of care being provided by the service. A financial audit was carried out by a representative from head office annually. These were carried out to ensure the care and safety of people who used the service.

People and relatives told us managers were supportive and approachable. Their comments included, "I tend to go to a certain line manager if I have any problems. I don't know if there is or who the manager is currently", "If I ever needed to speak to the manager here I would but I am not really sure who it is now", "Staff morale is better since [Name] has come upstairs" and "Staff and management are first class."

Staff told us and meeting minutes were available to show regular staff meetings took place and these included general staff meetings, senior support worker, domestic staff, night staff and kitchen staff meetings. Staff meetings kept staff updated with any changes in the home and to discuss any issues and developments.

Regular monthly analysis of incidents and accidents took place. We were told learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence. For example, we noted the staff meeting minutes for July 2016 had discussed the increase in the number of falls.

The management team had introduced an electronic individual quality assurance initiative called "My days" to make sure people were listened to and they enjoyed preferential treatment. This included menu planning, activities, laundry and housekeeping services. This involved a named person each day being visited by heads of department and consulted about their wishes and preferences. It also included their bedroom being spring cleaned and their favourite meal being prepared. This was to assist in the provision of person-centred care.

People, staff and relatives had the opportunity to comment on service provision. We noted where previous areas of improvement had been highlighted such as menus. People were surveyed for their comments and daily surveys were also produced to monitor the quality of food. An annual survey was sent out by the provider and in 2017 one relative commented, "I can honestly say the treatment and care [Name] has

received is excellent. I would recommend the service to anyone considering an option for a loved one." An electronic system had also been introduced in 2017 to capture people's and relatives views of the service in order to improve service provision. At the time of inspection analysis of results was not available to show the action taken in response to people's comments. Staff also had the opportunity to comment about different aspects of the running of the service such as staff training. We saw several comments about service provision.

We recommend the provider advertises within the home the results of surveys to show the action that is taken as the result of feedback about the service. This will show people who use the service, relatives and staff what the service does well. It will also demonstrate that they are listened to and it will show the resulting action that has been taken if it is required.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Robust systems were not in place to ensure service users at risk of poor nutrition and weight loss were adequately monitored. . Regulation 14 (1)(4)(a)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always handled effectively according to the homes complaints procedure. Regulation 16(1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured systems and processes were established and operated to ensure compliance with the registered persons need to: assess, monitor and improve the quality and safety of the service; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, maintain an accurate, complete and contemporaneous record for each person; evaluate and improve their practice. Regulation 17 (2)(a)(b)(c)(f)

The enforcement action we took:

A warning notice was served as the registered person had not ensured systems and processes were established and operated to ensure compliance with the need to: assess, monitor and improve the quality and safety of the service; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, maintain an accurate, complete and contemporaneous record for each person; evaluate and improve their practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe and person centred care to people at all times. Regulation 18 (1)

The enforcement action we took:

We served a warning notice to the registered provider as staffing levels were not sufficient to provide safe and timely care to people who used the service.

Regulation 18(1)