Twinglobe Care Homes Limited

Aspray House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10, 13 and 16 November 2017. The first day of the inspection was unannounced.

Aspray House is a care home with nursing for up to 64 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Aspray house is divided into four units providing nursing care to older adults. It is a large purpose built care home that is fully accessible to people with mobility needs. At the time of our inspection 61 people were living in the home. Many of the people living in the home were living with dementia.

The home did not have a registered manager. The last registered manager had left recently, and the new home manager was in the process of applying to register with us. 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 the last inspection in January 2017 we asked the provider to take action to make improvements in relation to choking risk assessments and staff training in relation to choking. The provider had taken action to address these concerns.

At this inspection we found that needs assessments, care plans and risk assessments lacked detail and were not personalised to each individual. They lacked detail regarding care preferences including personal care, dietary needs and end of life wishes. Records of care did not show people were supported to have their needs met.

The home had high agency use and this affected people's experience of care and views on the attitude and number of care staff.

Staff had not received the training and support they needed to perform their roles. Staff were using physical intervention when supporting people with personal care and had not had training on how to do this in a safe way.

The home had not always sought consent in an appropriate way, and some care files contained conflicting information about people's capacity to consent to care. Staff did not demonstrate a sound working knowledge of the Mental Capacity Act 2005.

The governance arrangements in place had identified issues with the quality and safety of the service, but actions in place had not been effective in improving the experience of people living in the home.

Staff were knowledgeable about safeguarding adults from harm, and the provider took appropriate action to investigate and respond to allegations of abuse and other concerns raised. Some people told us the previous manager had not responded to their concerns, and the new manager addressed this immediately.

The home was clean and well maintained. The home was coming to the end of a programme of refurbishment which included replacing flooring which had previously been malodourous.

People living in the home had complex healthcare needs. They received support to access healthcare services and the home worked appropriately with healthcare professionals to ensure people's needs were met. People were supported by qualified staff to take their medicines as prescribed.

Staff demonstrated they understood how to provide compassionate care, and how to promote people's dignity. Staff demonstrated they understood the impact people's sexual orientation might have on their experience of care. However, sexual orientation was not included as part of the care assessment and planning process. We have made a recommendation about supporting people who identify as lesbian, gay, bisexual or transgender.

The provider had a clear complaints policy and the new manager had introduced systems to ensure people and relatives were able to provide feedback about their experience of the home. Some people said their previous complaints had not been responded to.

Activities were delivered with enthusiasm but lacked purpose and focus. The manager had plans in place to develop the activities provision within the home.

The manager engaged with us, and external agencies provided feedback about the service. The service was developing a plan to address concerns in the home.

We found breaches of five regulations relating to person centred care, consent, safe care and treatment, good governance and staffing. You can see what action we told the provider to take at the back of the full version of the report.

The last inspection, completed in January 2017 was a focussed inspection. That inspection rated the key questions Safe and Effective as requires improvement and changed the overall rating to Requires Improvement. This inspection found the service continued to be Requires Improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Measures in place to mitigate risks faced by people were not always clear. Staff were using physical interventions without proper training in how to do so safely.

There was high use of agency staff and people told us this affected their experience of care.

The service ensured staff were suitable to work in a care setting, but the interview process was not always clearly recorded.

People were supported to take their medicines in a safe way.

Staff were knowledgeable about safeguarding adults from harm. The service took appropriate action in response to incidents.

The service was clean and had effective systems to protect people by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective. People's needs and preferences, including their dietary preferences, had not been clearly established through the needs assessment process.

Staff had not received the training and support they needed to perform their roles.

Staff did not demonstrate they understood the application of the principles of the Mental Capacity Act 2005 and the service was not always seeking consent in line with legislation and guidance.

The service was adapted to meet people's physical needs.

People were supported to have their healthcare needs met, and the service worked with healthcare professionals to ensure people received the treatment they needed.

Is the service caring?

Requires Improvement

The service was not always caring. People told us they had mixed experiences of the attitude of care staff.

People and staff told us high agency use affected the nature of relationships developed.

Staff demonstrated a good understanding of the impact of sexual orientation on people's experience of care, however, sexual orientation was not considered in care plans or assessments.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs and preferences, including their end of life wishes, were not clearly captured in care plans.

Records of care did not show people had received the care they needed.

The provider had a robust complaints policy, and complaints recorded had been responded to appropriately. However, some people told us their concerns had not been acted upon.

The activities provision was enthusiastic but lacked focus and was not always suitable for people living in the home.

Is the service well-led?

Requires Improvement

The service was not always well led. Audits had identified issues with the quality and the safety of the service, but the actions to address these concerns had not been effective.

Staff had clear job descriptions with their roles and responsibilities clearly defined, but it was not always clear staff were completing all aspects of their role.

People and staff spoke highly of the new home manager and were enthusiastic that the home was improving.

The service had a clear statement of purpose and set of values that were available to all.

Aspray House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Following the last inspection, in January 2017, the provider had addressed the concerns we identified around choking. However, other issues of concern had emerged by the time of this inspection.

Aspray House accommodates up to 64 people across four floors of a purpose built care home. One of the floors specialised in supporting people with complex nursing care needs, including people receiving end of life care. Another floor specialised in providing nursing care to people living with dementia. Many of the people living in the other units were also living with dementia.

Before the inspection we reviewed the information we already held about the service. This included notifications the provider had submitted to us. A notification is information about important events which the service is required to send us by law. We sought feedback from the local authority contract monitoring team. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection took place on 10, 13 and 16 November 2017. The first day of the inspection was unannounced. The inspection was completed by one inspector, a specialist advisor who was a specialist in nursing care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with eight people who lived in the home and two relatives. We observed care delivered in communal areas of the home, including activities. We spoke with 16 members of staff including the home manager, the quality manager, the training manager, the maintenance manager, the chef, the senior housekeeper, an activities coordinator, three nurses, a student nurse and five care workers. We reviewed the care files of 13 people including assessments, care plans and records of care delivered. We

reviewed 11 staff files including recruitment and supervision records. We also looked at the training records, complaints, incidents and various other policies, documents and audits relevant to the management of the service. We asked the provider to send us updated versions of some of the documents we viewed during the inspection as well as some policies and audit documents. These were submitted within 48 hours of the site visit.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in January 2017 we found risk assessments for people who were identified as being at risk of choking were not specific to the individual and did not provide clear guidance for staff on how to respond to incidents of choking. The provider had addressed this and there were clear risk assessments with detailed eating and drinking guidance in the files of people who were identified as being at risk of choking. These included details of the consistency of food and fluids as well as the best seating position to mitigate the risk of choking.

Risks faced by people during the delivery of care were identified during the assessment and review process. The measures in place to mitigate risks were not always clear. Where people required support to reposition or move, the moving and handling risk assessments lacked detail about the nature of support to be provided. For example, one person required the support of a hoist to transfer as they were unable to weight bear. The risk assessment identified the make and size of sling but then stated, "[Person] requires full assistance of two staff to transfer from bed to chair." There were no further details to inform staff about the nature of the assistance required.

A second person was nursed in bed and required support for all movements. Their risk assessment stated, "[Person] request full assistance of two staff for all transfers. Staff explain to [person] what are you going to do and make her comfortable and safe." There were no details to inform staff how to ensure this person felt both comfortable and safe.

People were identified as being at risk of developing pressure wounds. Where people had developed wounds the wound management plans were clear with detailed records maintained by nursing staff. However, the measures in place to reduce the risk of developing wounds were not always clear and consistent. For example, risk assessments detailed that people should be supported to change their position but did not specify the frequency of repositioning required. In one person's care file different parts of the plan referred to two hourly, three hourly and four hourly repositioning. This meant there was a risk people were not supported to change their position at the required frequency and may develop pressure damage.

People living in the home were described as presenting with verbally and physically aggressive behaviour, particularly while receiving support with intimate care tasks. This was identified as being a risk to both the person and the staff supporting them. The information about how the risks were mitigated was insufficient and meant people were at risk of unsafe care. For example, one person had a care plan and risk assessment called 'challenging behaviour.' This told staff, "Ensure to let them know what is going to happen before you do it. E.g. show them a new set of clothes, pad, or show a shower so that they can know what to expect. This might help with getting their compliance. In a situation when they are agitated and / or aggressive try to find out what triggered it." There were no further details to inform staff how to respond to aggressive behaviour from this person. Their care plan, and that of another person, noted that it sometimes required three of four staff to support them with personal care, however, there was no information about how staff should provide this support.

A record of care stated, "[Person] was very violent when putting them to bed. We managed to restrict their violence by holding his hands and legs. They were successfully changed and left alone." The home manager confirmed staff were using physical interventions, holding people's arms and legs, to complete care tasks. There was no information in the care files to describe how to do this safely. The training manager confirmed no staff had received any training in the use of physical intervention. One care worker said, "It can be frightening working with people who are violent."

We discussed our concerns with the home manager, who liaised with the local authority and submitted updated risk assessments regarding the use of physical intervention. Although they contained more information, it was still not clear how staff should be intervening in a safe way. For example, the updated risk assessment stated, "Gently prevent [person] from lashing out by applying pressure at the point of resistance with one hand while communicating with the other member of staff and changing / cleaning with the other hand." This was not a clear instruction about how to ensure the safety of the person or staff during personal care and meant there was a risk of unsafe restraint of people.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives gave us mixed feedback about whether they felt safe in the home. One person said, "I feel safe." Another person told us, "I feel safe, but not relaxed." A third person said, "I feel safe here, the staff are very busy but kind." Two relatives told us they visited daily because they did not feel confident their family members were safe if they did not visit. People and relatives told us the main reason they did not feel safe was due to inconsistencies in the staff supporting people. Care workers also told us there was high agency use in the home and this had an impact on the care they were able to provide. One care worker said, "It's difficult with agency staff, they don't know people so well so it doesn't feel like the work gets shared out evenly. It's better when it's all permanent staff on duty." The home manager told us they recognised the impact of high agency use and had recently completed a recruitment drive for permanent care staff, some of whom had already started working at the home.

The home manager completed regular reviews of staffing levels at the home. At the time of our inspection the usual allocation was three nurses and 12 care workers during the day, with three nurses and seven care workers at night. One of the nurses worked across two floors. Observations during the inspection showed there were times of the day, particularly around mealtimes, when people had to wait for their support. The home had a call bell system for people to call for support. We requested an analysis of the call bell response times in order to help us judge whether staff were effectively deployed but were told the system did not allow for this type of analysis. The staffing rota was viewed which showed a pattern of reducing agency use. However, during the week before our inspection there was one occasion where four out of the seven staff on duty in one unit were agency staff, another occasion when three out of seven staff on one unit were agency and a third occasion where three out of eight staff on one unit were from an agency. This meant there was a risk of a lack of continuity in the experience of people receiving a service.

The provider told us agency staff were used to provide additional one-to-one support to people who required it. They also told us agency staff worked alongside experienced, permanent staff members. However, although it was recognised that recruitment was taking place, people's experience was still affected by high agency use.

Recruitment records reviewed showed nurse recruitment included an evaluation of their knowledge and understanding of their role and responsibilities. Records for the interviews of care workers and activities coordinators did not include any detail regarding how candidates answered questions or how judgements

were formed. For example, one care worker interview record simply stated, "Spoke competently" about dignity and, "Demonstrated caring approach." The section of the form to indicate the success of the candidate had not been completed on care worker or activities coordinator recruitment. Staff had completed assessments of their literacy and numeracy skills as part of the application process. These had been marked, but there was no record to show what the results led to, even when they identified that nursing staff had made mistakes with basic numeracy tasks. This meant the recruitment processes had not been operated robustly as it was not clear candidates had been appropriately assessed for their role.

Records showed the service collected references and completed appropriate checks of people's character, including criminal record checks, before they started working in the home. This ensured that staff were of a suitable character to work in a care setting.

Staff were knowledgeable about safeguarding adults from harm, they were able to describe what action they would take if they were concerned that people were being abused or neglected. One care worker said, "I'd go and tell the nurse straight away [if I was concerned about abuse]. If they were not responding I'd go on to management. I'd complain in writing. I'm not afraid to do that." Records showed the provider took appropriate action when allegations were made, reporting incidents to the local safeguarding authority for investigation. Where allegations were made concerning staff conduct, the provider ensured they did not have contact with people until the outcome of the investigation was known.

A care worker explained how they supported people to feel safe. They said, "I communicate with them. I take my time. I'm gentle, I'll ask 'can you raise your arm' that kind of thing. I'll make sure they're warm enough." This meant the home had effective systems in place to safeguard people from abuse.

Records showed people received their medicines as prescribed. Medicines were administered by trained nursing staff and we saw medicines were administered in a calm and unrushed manner ensuring people had the support they needed to take their medicines. Medicines were stored safely and securely at appropriate temperatures, including medicines that required refrigeration.

Nursing staff were responsible for administering medicines and this included 'as needed' medicines such as pain relief. There was limited guidance for staff about when to offer and administer 'as needed' medicines. This was identified by an external medicines audit completed by the supplying pharmacist the day after our inspection. This audit identified a number of issues with the recording of refusals of medicines and ensuring records were accurate and up to date. The home manager incorporated this feedback into an action plan which was submitted to us after the inspection.

We saw the home was clean and there were no malodours throughout. The housekeeper showed us they maintained a clear system for ensuring daily routine and regular deep cleaning of the home. The service had appropriate arrangements for ensuring laundry was processed in a way that reduced the risk of infection. We saw staff had suitable personal protective equipment available to them, such as gloves, aprons, hand washing facilities and sanitisation gels to ensure infection was prevented and controlled. There were systems for reporting maintenance concerns and records showed these were completed in a timely manner. The maintenance team carried out relevant health and safety checks to ensure the building was safe for people.

Incident records showed the service investigated and responded to concerns in a timely and appropriate manner. Where it was appropriate people's care plans and risk assessments were updated, or referrals made to healthcare services. The paper records in the service had a section to be completed regarding any follow up actions or lessons learnt. This was not completed on the paper documents. After the inspection

the home manager submitted their records of incidents with the lessons learnt. This showed training was being arranged for staff regarding skin care and supporting people who could behave in an aggressive way. This meant the provider was ensuring that lessons were learnt from incidents.

Requires Improvement

Is the service effective?

Our findings

The provider completed needs assessments before people moved into the home. Records of assessments completed showed these considered people's religious and cultural needs, as well as care, nutrition, and behavioural support required. These assessments led to the creation of care plans which were broken down into different areas of care including continence, medicines, mobility, nutrition and hydration, sleeping, personal hygiene, and social wellbeing. Where it was identified as a need care plans were created in relation to behaviours which were described as challenging.

Care plans in relation to skin care and wound management, where people had already developed wounds, were highly detailed and demonstrated the home was using and applying best practice guidance. However, other aspects of the care plans were not goal focussed and did not demonstrate the provider had kept up to date with best practice in supporting people living with dementia. There were no dementia specific care plans in the files of people diagnosed with dementia, and a lack of goal focus in other care plans viewed. There was no detailed or personalised information about the impact people's diagnosis of dementia had on their lived experience or guidance for staff on how to ensure people were not disadvantaged by their diagnosis.

People gave us mixed feedback about the food in the home. One person said, "It's not too bad, it's better than the army." However, other people told us the food was bland and overcooked. One person said, "The food is not very good. The menu is repetitive. There's only ever sandwiches for dinner." A second person said, "The food is decent quality but I've lost my sense of taste. But it's always overcooked, the vegetables are soggy." We saw that most people living in the home took their meals in their bedrooms and staff distributed meals from a servery based on each unit. On two days of the inspection we saw that lunch did not arrive on the units until 1pm, although staff told us it was usually served nearer to 12:30pm. We saw people asking where their lunch was, and complaining that it was late. People whose bedrooms were furthest from the servery did not receive their meals until nearly 2pm.

Where people needed support to eat their meals, this was provided by care workers. However, information about people's dietary preferences was limited in care files viewed. Most care files recorded that people were "not fussy" or wanted a "normal diet." The kitchen contained dietary preference sheets for all people living in the home, but these were similarly lacking in detail regarding people's preferences. Eight of these sheets were viewed and only one had named preferences, three stated, "normal" two liked, "puree", one stated the preference as "soft diet" and the final one was blank. The chef told us he devised a rolling seasonal menu, but was not able to explain how people were involved in choosing what went on the menu. People's weight was monitored and food fortified to increase calorific intake if people were identified as losing weight. However, records of care delivered did not capture what, or how much people had eaten so it was not clear that people were routinely supported to eat and drink sufficient amounts.

The above issues regarding the lack of details of people's preferences being established through the assessment process are a breach of Regulation 9(3)(a).

The impact of this was exacerbated by the fact that staff had not received training that was relevant to their role. For example, staff had not received training in the use of physical intervention and this was not being considered until it was pointed out as being a need by the inspection team. Training records showed staff completion rates for the provider's required training were low. Only 53% of care and nursing staff had in date training in record keeping, 44% had valid diabetes training, 53% had training in equality and diversity, 60% had completed dementia awareness, 21% infection control and only 53% had in date health and safety training. Although most staff had completed these courses at some point, they had not completed the refresher training as required by the provider. This meant there was a risk that people did not receive effective care as staff had not maintained their training.

The provider's policy stated staff should receive a minimum of six supervision sessions a year, which could include team or group supervisions as well as one-to-one meetings with their named supervisor. Supervision records showed that 41% of staff who had been employed for at least a year had not received six supervisions in the last twelve months. The records showed that almost all staff had received a supervision since the new home manager had started.

The quality of supervision records varied. Some included a discussion of roles and responsibilities and provided staff with the opportunity to discuss people they supported and any concerns they had at work. However, nurse supervisions were reviewed and although they recorded nurses' responsibilities they did not provide support or guidance on how to meet these. For example, one record stated "[Nurse] is accountable for her action. She is responsible for all her residents, staff, premises and equipment. [Nurse] has the right to take action in the best interests of her residents and team. She has the right to discuss issues with other RGN / RNs in the building and solve issue. Return [agency] staff home if refuse to work. Call [deputy manager] any time of the day and night for assistance. Do not feel intimidated by care staff." There was no guidance to support the nurse in achieving these actions which meant there was a risk they had not received the support they needed to do so.

The above issues with training and supervision of staff are a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff told us they received a comprehensive induction when they started working in the home. This included three days of classroom based training and shifts where they shadowed more experienced staff members. Care workers told us they were assigned a mentor who helped them get to know their role and responsibilities. One care worker said, "It felt really organised. The whole induction and training was really good. They made sure we know what the policies are and how to follow them. I wasn't just dumped in the units."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest 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 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. Where people lacked capacity to consent to their care and treatment the provider had made appropriate applications to the local authority to deprive them of their liberty. Copies of these authorisations were contained within care files ensuring staff were aware of people who were deprived of

their liberty.

However, records regarding people's capacity to consent to various aspects of their care were unclear. For example, in one care file the person was stated as lacking capacity in one section, but described as having full capacity to make decisions about their treatment in another section. Records showed relatives had signed consent forms for some medical interventions but it was not clear they had legal authority to do so. Relatives can only consent on people's behalf if they have the appropriate legal authority to do so. Where someone has nominated a decision maker for situations when they lack capacity, and this has been recognised by the Court of Protection, this is called a Lasting Power of Attorney (LPA). We asked the provider for records about relatives who had legal authority to make decisions about care and treatment on behalf of people living in the home. The records submitted showed only one person had a relative duly authorised to make decisions about their care and treatment. Despite this, we saw relatives had signed to indicate consent on care plans reviewed.

Staff understanding of the MCA and its application varied. Some care workers demonstrated they understood the importance of continuing to offer people choices and respected their decisions, even if they were considered unwise. One care worker said, "They all have the right to make their own decision. I always offer a choice of clothing. I'll follow their eye contact or where they look. I use any means to establish what their choice may be." Other staff did not demonstrate they understood the MCA. One care worker said, "I am not sure [about the MCA] but I have done the training. It's to do with choice and safety." They were unable to provide more information about the MCA. When asked about one person's capacity to make decisions one nurse said, "[Person] can explain but sometimes they get confused so the family put they lack capacity. We ask the family about all decisions." The nurse had not heard of LPAs and when asked about the approach to decision making for people who lacked capacity was very task focussed. They said, "If they lack capacity we get an assessment from professionals. Then we do a form and there's authorisation for the best things." This does not demonstrate an understanding of the five principles underpinning the MCA.

The above issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care files contained information about people's healthcare needs and diagnoses. Records showed people were supported to access healthcare services when they needed. Staff made records of GP visits and specialist healthcare professionals input. The provider worked with their supplying pharmacy and local Clinical Commissioning Group to ensure people's healthcare needs were met. Staff kept records of health appointments recording the advice of healthcare professionals. However, where people lived with long term health conditions, such as diabetes, there was limited information for care workers about how to identify and respond to concerns. For example, care plans advised staff to be alert for signs of hypoglycaemia and hyperglycaemia but did not describe the symptoms to support staff in identifying these conditions. Care workers told us they would report any concerns about people's presentation to nursing staff, who were professionally qualified to identify these conditions.

The building was fully adapted for people's needs and each floor had fully accessible bathrooms. People's bedrooms had been personalised with their own belongings and pictures. During the inspection the home was coming to the end of a programme of redecoration. This had included replacing the flooring which had previously been malodourous.

Requires Improvement

Is the service caring?

Our findings

We saw some positive interactions between staff and people living in the home. For example, we saw one person in a lounge sat with the same staff member throughout the morning, engaging in conversation and sharing comments about the programme on the television.

However, we also saw some less positive interactions. For example, we saw one staff member reposition a person in their wheelchair by moving them backwards without speaking to them first. We also saw another person who was re-arranging their clothing in a public area of the home was spoken to in a tone that sounded like they were being told off, rather than supported to maintain their dignity. This person was also physically escorted to another room and it was clear from the way they pushed the staff member away that it was not their wish. Another member of staff intervened and supported the person to calm down. This incident was discussed with the home manager who advised the staff member concerned was an agency worker and they were already addressing concerns with their performance.

People told us some care workers displayed a caring and compassionate attitude. One person said, "They [care workers] are lovely. I don't know where I would be without them." Another person said, "They are good." However, another person said, "Some are lovely, some are the opposite. They can be unapproachable and have attitude." A fourth person said, "Some of them rush doing the job. Their mind is not on the job, they are talking to each other."

Care workers told us their ability to deliver compassionate care was sometimes affected by staffing levels and high agency use. One care worker said, "We're a good team here. We get the residents up. Sure it is busy and we could do with some help at times, but our job is to get them up, dressed and to the toilet when they need to." Another care worker said, "Sometimes we need more staff. It's good if you have time to talk to people about the photos in their room, or to sit and watch a bit of telly with them. We don't always have time to do those things." This meant people were not always receiving compassionate care as there was variety in people's experience of staff attitude.

Care plans contained information about people's religious beliefs and faith representatives visited the home regularly so people were supported to practice their faith if they wished. Staff told us people were supported to practice their faith and if they required a specialist diet due to religious beliefs this was provided.

Care plans named people's key relationships. However, information about people's sexual orientation was not included in the documents. Staff told us people's sexual orientation would not affect the care they delivered. One care worker said, "I've not come across that [anyone who identified as lesbian, gay, bisexual or transgender]. It wouldn't affect how I work. At the end of the day people are human beings just the same." Another care worker told us, "I met a gentleman and his partner came in. I could see the relationship was different from a friendship so I asked. It's important to know, a partner is different from a friend and we should respect that. It wasn't in the care plan though." This demonstrated this care worker had understood the importance of ensuring people and their partners felt safe and confident to disclose their relationship and so it would be valued and respected by staff in the home. However, as it was not explored in assessment

and care planning there was a risk that not all people who identified as lesbian, gay, bisexual or transgender (LGBT) would feel confident to disclose their sexual orientation.

We recommend the service seeks and follows best practice guidance around supporting people who identify as LGBT in a care home setting.

We saw people were supported to maintain their dignity. If people were in their bedrooms with the doors open, care workers had ensured they were dressed and covered so they did not risk exposing themselves to people in shared areas of the home. People were supported to wear aprons and use napkins during mealtimes to ensure they remained well presented. Care workers described the steps they took to ensure people's dignity was maintained, such as keeping people covered during personal care, and ensuring curtains and doors were closed while receiving care.

Requires Improvement

Is the service responsive?

Our findings

Care plans reviewed lacked detail regarding people's preferences and views. In addition to the main care file, people had a document in their bedrooms called "My Life Story." One of the documents viewed had been completed by the person's relatives and contained information about their working life and personal history. However, others had been poorly completed or not completed at all. Within one, which had not been completed, there was a letter from the person's relatives stating a request that the person wished to be asked the questions, rather than staff referring to their relatives. Another "My Life Story" book contained no information about the person's life before they lived in the home, and stated their family was "One brother and one sister." No further information about these relatives was within the file, and there was no mention of their children who other records showed visited the home regularly. The provider also had short profiles about people called "About me" available in people's bedrooms. These included information about people's past employment and activities as well as current preferences for music and television. Although there were some details of people's preferences in these documents, they were high levels summaries and did not contain sufficient detail to ensure people received holistic, personalised care.

Other aspects of care plans contained varying levels of detail about how people wished to receive their care. For example, one plan contained detail regarding their abilities and preference, stating, "[Person] is able to help with upper body, face and hands, but requires full assistance with lower body." The plan included they liked, "Normal body wash and shampoo supplied by their family." However, there was no detail about what "normal body wash" was in case the family were unable to supply it. Another person's care file lacked detail about the nature of their care preferences. It stated, "[Person] prefers to have a bath, shower once a week." The plan noted they liked bubbles in their bath but the only other information for care workers stated, "Two carers to assist [person] into the bath." And "Wash [person] every day." This did not describe to care workers the exact nature of the support to be provided.

Other care plans contained generic information regarding continence care. Although the nature of continence aids were described, staff were instructed to check on people "regularly" or told people required "constant monitoring" but there were no details on the frequency of checks and support to guide care workers in their support.

Information about how to support people to communicate their preferences was limited. Although some people did not use speech to communicate, or used languages other than English, their care plans did not provide clear information about how to facilitate meaningful communication and elicit choices and preferences. For example, one person's care plan stated, "[Person] has lost the ability to communicate. Staff to develop a therapeutic and meaningful relationship. Staff to give [person] care that is respectful, sensitive, compassionate and empathetic." There was no guidance for staff about how to do these things.

Two care workers told us they had not had time to view care plans since starting working in the home, and had learned about people's needs and preferences from more experienced colleagues. One care worker said, "I've not had a chance to look at the papers. We have a meeting each morning to update on each person. I learn about people from that and the shadowing I did." Another care worker said, "I've not exactly

had a chance to go through the care plans yet. I asked my colleagues. I ask the ones who know people better what I need to know, if people have any preferences and how to talk to them."

Records of care delivered did not contain sufficient information to establish if people had been supported in line with their needs and preferences. Notes were generic and repetitive. Two of the care notes viewed contained identical entries, recording on multiple occasions, "Received personal care and medication from the nurse. Safety ensured at all times. Pads changed when needed." Where people had recorded preferences for having a bath or shower on a regular basis, it was not possible to tell from the notes whether these preferences had been respected, as the notes simply recorded that personal care had been given rather than the form the care had taken.

Some of the people living in the home were approaching the last stages of their lives. Where people had valid "Do Not Attempt Cardio Pulmonary Resuscitation" (DNACPR) authorisations these were in a prominent position within their care file, and were regularly reviewed by healthcare professionals to ensure they remained valid. Care plans contained a section regarding people's end of life wishes. These care plans focussed on the practical aspects of dying and CPR status and did not include information about pain relief or the emotional and spiritual aspects of death.

Two care files contained conflicting information about the people's end of life care wishes. One person had a valid DNACPR on their file, however, their end of life care plan stated their family wished for them to be resuscitated. Another person's record showed they had clearly expressed to their GP that they did not wish to be resuscitated and were considering withdrawing from treatment. The GP had noted they were on a palliative care pathway. However, their end of life care plan stated, "When his heart stops to beat the qualified staff need to start CPR. His DNAR form has not been signed." The plan also stated this person's family wished for an ambulance to be called and resuscitation to be attempted. This meant there was a risk that resuscitation would be attempted when this was against the person's clearly recorded wishes.

The above issues are a breach of Regulation 9(1)(b)(c)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had recently recruited additional activities coordinators and there were now five activities coordinators working in the home. The home manager told us the plan was that as soon as the new staff had completed their induction period, there would be activities provision seven days a week. Observations showed the activities were delivered with enthusiasm and a cheerful attitude. We saw staff engaging people in both group and one-to-one activities.

However, the selection, structure and purpose of activities were not clear. Although there was a large activities board in the home, with smaller versions on each of the units, they were not fully completed so it was not clear to people what activities were available for them to choose from. We asked an activities coordinator how they selected activities and they said, "We see how many of us [activities staff] are here. If there are more than two activities coordinators here we'll do a group activity. We have lots of nice games, throwing games, art things like painting or colouring. Sometimes we do karaoke. There's lots of music. We decide day by day, it depends on the resident."

Feedback from care workers reflected our observations about the provision of activities. One care worker said, "They [activities coordinators] do try. Sometimes it feels a bit like they are acting like children, like I would do if I worked in a nursery. It's not always something that relates to the people here. It's not about what they [people living in the home] liked doing when they were younger. The excitement is high though, and that's got to be positive."

The home manager recognised the activities provision within the home required support to become focussed and meaningful for people. The manager told us they were planning on developing the activities team, including provision of training to ensure they knew how to perform their roles.

The home had a clear policy regarding complaints, which included the expected timescale for investigation and response and how to escalate concerns if people were not happy. Records showed the home had investigated concerns in a timely fashion, escalating concerns to external sources where this was appropriate. However, people and relatives we spoke with told us they had raised concerns about the quality of care and had not received any response to their concerns. We established issues had been raised with the previous registered manager. The current home manager sought immediate feedback from these people and relatives to seek to address their concerns.

Requires Improvement

Is the service well-led?

Our findings

Following both internal audits completed by the provider's quality manager, and external reviews by the local authority and clinical commissioning group, the home had an action plan in place to address issues with the quality and safety of the service. Records showed the home liaised closely with the external agencies and responded positively to their feedback and comments. The internal audits had identified issues with the levels of detail and personalisation in care plans in June 2017. These issues had persisted and were still found during the inspection. This meant the actions in place to address these concerns had not been effective. The audits had not addressed that records of care were insufficient and did not show people had received the care required to meet their needs.

The internal audit had identified that no comprehensive audit of care plans was being carried out by the home staff, only spot checks were being completed. The action plan resulting from the June 2017 audit had been updated in October 2017 and established that comprehensive audits of care plans were still not taking place. The follow up audit for three of the units identified that out of 22 actions 14 had not been completed. However, 13 of these outstanding actions, including actions relating to the completeness and consistency of care plans, were marked as medium priority. The only action marked as requiring urgent action related to the use of a specific form to record mental capacity. The follow up audit for the fourth unit identified of the 14 required actions only six had been completed. This meant there had not been effective monitoring or oversight of the action plan to improve the quality of the service over the intervening months.

Staff files contained copies of people's job descriptions, which included details of staff responsibilities and accountabilities. For example, it was made clear that nurses were responsible for managing staff, writing and updating care plans as well as nursing care of people living in the home. Supervision records and staff meetings showed discussions around responsibilities for ensuring the quality of care and safety of people living in the home. However, regular checks on the quality of records were not captured or recorded so it was not clear that staff were meeting their responsibilities.

During the inspection the manager responded promptly to concerns raised. After the inspection the manager submitted an action plan to address some of the concerns identified. However, this did not have clear timescales for action and did not prioritise the issue of untrained staff using restraint techniques. Although the training manager was researching appropriate training for staff, this was in scoping stage. There was no clear timescale in place to ensure staff had received the training they needed to support people in a safe way. This meant the provider had not taken action to ensure people were supported in a safe way.

The provider had completed a survey for people, friends and relatives in 2016. The feedback from this had been mostly positive, with people and their relatives indicating they were satisfied with the overall quality of the service. However, some comments were not entirely positive, including people's level of involvement, range of activities and meals. There was no action plan associated with this survey.

The above issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The home did not have a registered manager. The previous registered manager had left recently, and the new home manager was in the process of applying to register with us. People and staff spoke highly of the home manager and told us they seemed to be focussed on improving the home. One care worker said, "I think [home manager] is brilliant. He's down to earth. I can communicate with him, he makes us feel like part of a team." Another member of staff said, "He is a humble manager. He comes and says hello. We see him on the units."

The home had a clear statement of purpose that was available to all people living in the home and their families. There was also a copy available in the reception of the home for visitors. Recruitment questions showed staff were asked questions to explore their values before starting work at the service.

The staff we spoke with told us they felt the home was improving and were motivated by management to improve quality. One member of staff said, "It feels fresh at the moment. It's positive and makes us want to work well."

Since the new manager had started working at the home in September 2017, there had been two meetings for people and their relatives. These had offered people and their relatives the opportunity to provide feedback about the service. People and their relatives had raised that it was difficult to get through to the home on weekends and a lack of variety in the food choices. Following feedback given during the inspection, the manager also emphasised to people and their relatives that they should not hesitate to raise any concerns they had directly with him.

Records showed there were regular meetings for staff in the home. Senior staff held a daily meeting called "take ten" to ensure key information was handed over to all staff in the units. In addition, each unit team did a daily walk around together to ensure key information about each resident was shared effectively with the whole staff team. Records showed staff meetings were used to share good practice examples. For example, issues with record keeping and handover had been discussed in staff meetings. These meetings gave staff a forum to raise issues and be involved in the development of the service.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Needs assessments and care plans were not robust and did not reflect people's preferences. Records did not show people were receiving the care they needed to meet their needs. Regulation 9(1)(b)(c)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Consent had not always been sought from the appropriate person. The service did not consistently demonstrate adherence to the principles of the MCA 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service had not appropriately identified or addressed risks faced by people receiving care. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not taken effective action to address concerns with the quality and safety of the service. Regulation 17(1)(2)(a)(b)(c)

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

Staff had not received the training and support they needed to perform their roles. Regulation 18(2)(a)