Acer Healthcare Operations Limited

Kents Hill Care Home

Inspection report

50 Tunbridge Grove
Kents Hill
Milton Keynes
Buckinghamshire
MK7 6JD

Website: www.kentshillcarehome.co.uk

Date of inspection visit:
14 February 2017

Date of publication:
31 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 14 February 2017. The provider of the service had changed since our previous comprehensive inspection; therefore this inspection was a first rating inspection for the service.

Kents Hill Care Home is located in a residential area of Milton Keynes and is registered to provide accommodation and personal care to people who may or may not have nursing care needs. They provide care for older people who may also be living with dementia and can accommodate up to 75 people at the service. When we visited there were 55 people living at the service.

The service had a registered manager. 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.

Staff members did not always receive effective support and training to perform their roles. Staff had not received regular supervision and had not been able to discuss any concerns they had about people's care, the service or their own development needs. Some staff members struggled with the electronic training system in place, however; had not had the opportunity to discuss this or seek alternative training methods. The provider had identified this issue and was working to resolve it.

Consent to care was sought on a daily basis but was not evidenced in people's care plans. It was not clear whether or not people agreed with the arrangements in place for their care, treatment and support. There were not robust systems in place to ensure the Mental Capacity Act 2005 (MCA) was used to support people who were unable to make decisions for themselves, or to show that decisions had been made in people's best interests. Provider checks had highlighted this concerns and work was underway to drive improvements in this area.

People's care was not always person-centred. Care plans did not show that people had been involved or consulted in their care arrangements. They were basic and did not provide staff members with sufficient detail to ensure they were able to provide care and support in accordance with people's needs and preferences. Staff members had individual knowledge of people at the service, but the current systems did not enable staff to record and share this knowledge with the rest of the team. There were activities for people to enjoy, however; the resources for this did not always ensure that all people were able to take part in activities. The new provider was working on making improvements in these areas.

Recent changes to the provider had unsettled some members of staff. They were not fully aware of the changes which were taking place, or what the future may hold. However; staff members still maintained a positive ethos and were motivated to provide people with the care and support they needed. They looked out for the people they cared for and were prepared to do the right thing for them.

There were quality assurance procedures in place at the service, but these had not always been effective in identifying areas for improvement. The provider had identified this and introduced a range of new checks and audits when they took over. The registered manager had worked to implement these new systems however; this had impacted on their visibility and availability to members of staff. They had however; worked hard to ensure they were still available to people and their families. Feedback and complaints were also welcomed and there were systems in place to record these and take appropriate action.

Staffing levels at the service were sufficient to ensure that people's assessed needs were met however; at times staff were very busy and became stretched. This meant that they were not always able to perform all aspects of their role. The recruitment procedures in place were robust and ensured that staff were suitable for their roles.

People felt safe living at the service. They were cared for by staff who were aware of abuse and the signs it may take. Staff were prepared to take action to reduce the risk of abuse and to report any incidents or concerns appropriately. There were systems in place to manage risks to people, visitors and staff and steps were put in place to reduce the likelihood that risks would occur. Systems were also in place for the safe storage, administration and recording of people's medicines.

The service provided people with a healthy and nutritious diet. People had a choice of what they wanted to eat and alternatives were provided where necessary. Support with eating and drinking was provided where necessary and specific dietary or cultural needs were accommodated. People were also supported to be at as good health as possible and the service assisted with appointments with a range of different healthcare professionals.

There were positive relationships between people and members of staff. Staff worked hard to get to know people and made sure they treated them with kindness and compassion. People and their family members were involved in the running of the service to ensure they were happy with the care they received and staff upheld people's dignity and respect whilst performing their roles.

We identified that the provider was not meeting regulatory requirements and was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the inspection report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels at the service were suitable to meet people's needs however; at times staff could become stretched and were not always able to perform their roles in full.

Staff members had been recruited following robust procedures.

People felt safe and were protected from harm or abuse by staff who had been trained to recognise potential signs and were aware of safeguarding and reporting procedures.

Risks were assessed and control measures were put in place to help manage risks to people, staff and visitors to the service.

There were systems in place to ensure people's medicines were managed and administered by trained staff.

Is the service effective?

Requires Improvement

The service was not always effective.

There were not always systems in place to ensure staff had the training, supervision and support they needed to develop the skills required to meet people's needs.

People's consent to their care and support was not robustly recorded. There were not always systems in place to ensure the Mental Capacity Act 2005 was applied for those people who were unable to make decisions for themselves.

The service supported people to maintain a healthy and nutritious diet. People had a choice of food and drink and were provided with the support they needed with eating and drinking.

People were supported to be at the best health possible. Appointments with healthcare professionals were booked and staff helped people to attend them where necessary.

Is the service caring?

Good

The service was caring.

Staff members treated people with kindness and compassion and worked hard to develop positive relationships with them.

Information about the service was available to people and their relatives and they were involved in the running of the service.

People were treated with dignity and respect by staff at the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The arrangements in place for people's care and support were not always person-centred. Staff had a good understanding of people's needs and preferences, however; care plans did not reflect this.

There were activities for people to take part in, however; it was not always possible to ensure that each person had the opportunity to take part in activities of interest to them.

Feedback, including complaints, was welcomed by the service. They were appropriately managed and used to help improve the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The recent change of provider had created unease within the staff team, which had affected the culture at the service. Staff had maintained a positive ethos however; and were committed to meeting people's needs.

Quality assurance systems had not always been effective in driving improvements. New processes had been introduced by the new provider to help drive improvements at the service.

The registered manager was available for people at the service, however; due to the workload associated with the recent changes, staff did not feel as well supported as they had been in the past.

Kents Hill Care Home

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.

This comprehensive inspection took place on 14 February 2017 and was unannounced. The inspection team comprised of two inspectors and an expert by experience. An expert by experience is a person who has person experience of using or caring for a person who may use this type of service. In this case the expert by experience had a history of caring for family members who may use this type of service.

Prior to the inspection we reviewed all the information we held about the service. This included statutory notifications which the provider had submitted to the Care Quality Commission (CQC). Statutory notifications contain information about specific incidents or events, such as safeguarding concerns, which the provider is legally obliged to tell us about.

During the inspection we spoke with 13 people who lived at the service and five of their visiting family members to seek their opinions about the care and support that they received. We also carried out observations of the interactions between people and members of staff as well as the care provided at key times of the day, such as activities, when medication was given and when lunch was served.

We spoke with a number of staff members covering a wide range of different roles within the service. These included two nurses, two team leaders and four care assistants. We also spoke with a housekeeper, the chef, the maintenance person, the residents' coordinator and the activities coordinator. Throughout the inspection we spoke with the registered manager as well as the senior quality assurance manager, who was visiting the service on the same day.

We reviewed the care records for 12 people across the different floors of the service, as well as 16 people's medication records, to ensure they were an accurate reflection of the care people received and to see if they were up-to-date. We also looked at staff recruitment files for 12 staff members, to check information regarding staff recruitment, training and support. In addition, we looked at further documentation regarding

the running of the service, including quality assurance checks and audits, to review how the service was managed.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were not always sufficient at the service. People told us that staffing levels at the service meant their basic care needs were being met. They explained that staff were sometimes stretched, but they were usually able to provide the support they needed in a timely manner. One person told us, "I do feel that they are overstretched sometimes but even when I ring by bell they are never normally more than five minutes." Another person said, "They are rushed off their feet sometimes."

Staff members told us that staffing levels were usually sufficient to meet people's needs, however; they were not always able to go the extra mile for people as they would have to see to the next person's needs. Staff members explained that the demands on nursing staff was such that they sometimes found it difficult to perform additional tasks, such as robust reviews of care plans. One staff member said, "With one nurse on the floor it is horrendous."

We spoke with the registered manager and the senior quality assurance manager about staffing levels at the service. They showed us that these were set using a dependency tool which calculated the numbers of staff required, based on people's specific care and support needs. They told us that they planned to review the tool and the results it produced, to ensure that staffing levels were sufficient to meet people's needs. They acknowledged that current staffing levels and distribution needed to be reviewed and had plans in place to do so.

There were robust recruitment processes in place at the service. Staff members told us that the service carried out background checks before they were able to start working, including Disclosure and Barring Service (DBS) criminal record checks and previous employment histories. One staff member said, "They did checks before I could start doing any shifts." The registered manager showed us that staff recruitment files contained records of checks which had been completed. They also showed us that checks were being carried out of staff files, including by human resources managers from the provider, to ensure they contained the necessary information. This demonstrated that staff recruitment ensured that new staff were of good character and suitable to work at the service.

People felt safe at the service and had no concerns regarding the staff or others living there. One person told us, "I feel safe because they look after me and I have a lovely clean room." Another person said, "I feel safe, there is nothing for me to worry about here. I'm well looked after." People's relatives also felt that their loved ones were kept safe by the service. One relative told us, "I have never seen anything untoward here, all very genuine."

Staff members told us that they had been trained in abuse and were able to tell us about the different types and potential signs of abuse. All the staff we spoke with told us that they had been trained in safeguarding and knew the procedure for recording and reporting suspected abuse. One staff member said, "I have no problems raising concerns. I would speak to the manager, or one of the nurses who oversee when she is not here." Another told us, "I'd speak to the team leader or one of the nurses about any safeguarding. I've done the training and know when I need to say something." Records confirmed that staff members received

safeguarding training and regular updates, to ensure they were aware of their responsibilities in terms of preventing, recognising and reporting abuse.

The registered manager showed us that, since the provider had changed, a new comprehensive safeguarding policy had been introduced. They explained that staff members were getting used to this and were also aware of the local authority policy and reporting guidelines. We looked at safeguarding records and found that incidents were reported in a timely manner. Appropriate external bodies, such as the Care Quality Commission (CQC) and local authority safeguarding team were contacted and appropriate action was taken to manage the incident.

There were systems in place to recognise and manage risks to people at the service. Staff members told us that they were aware that the new provider planned to improve the current system for assessing risk and they were positive about the impact that this would have. One staff member said, "Risk assessments have always been done but I've noticed them more now." We saw that risk assessments were in place for areas such as falls, mobility and malnutrition. Monitoring charts such as the Malnutrition Universal Screening Tool (MUST) and Waterlow charts, to monitor the risk of pressure wounds, were also in place and used on a regular basis. This meant that specific risks to people's health and well-being were assessed and actions were put in place to monitor and respond to risk to help keep people safe whilst still trying to maximise their independence.

Risk assessments were also in place to ensure people, staff and visitors were safe in the event of an emergency. Each person had an individual Personal Emergency Evacuation Plan (PEEP) in place which contained information about people's conditions and mobility which would have an impact on the support they required to safely evacuate the building. General risk assessments were in place for the building and we saw that checks and servicing of equipment, such as fire alarms and extinguishers, took place on a regular basis to ensure they were operational. There were emergency plans in place and evacuation drills were carried out to ensure that staff knew what they had to do in emergency situations.

People's medicines were well managed by the service. None of the people we spoke with had any concerns regarding their medicines and told us that staff made sure they had the right ones at the right time. One person said, "They make sure I get my tablets, they are very good with that." During the inspection we saw people being given their medicines. Staff made sure they prepared the right ones and explained to people what they were being given. People were given time to take them and were offered pain relief when required to make sure they were comfortable.

Nurses gave people's medicines on the two nurse-led floors of the service and team leaders or senior care staff gave them on the residential floor. Staff members told us that they received training so that they knew the correct way to administer and store people's medicines. One staff member said, "I received training in medication and had an annual audit, that's all been fine." We saw records to show that staff had training and competency assessments, to ensure they had the right skills and knowledge to give people's medicines safely.

We looked at the records in place for medication administration and storage, including people's Medication Administration Record (MAR) charts. These showed that people's medicines had been regularly given and staff had signed to say that they had been given. Records also showed that stock levels of medicines were correct and systems had been implemented to ensure on-going checks were carried out to stay on top of stock levels. There were also checks of how medicines were stored, including the temperatures they were kept at, which helped to maintain the efficacy of the medicines. There were suitable systems in place for the storage and administration of people's medicines.

Requires Improvement

Is the service effective?

Our findings

Staff members were not always provided with support and supervision by the service. Staff members had not had regular supervision or appraisal opportunities to discuss concerns or their own development. One staff member told us, "I haven't had an appraisal for some time, maybe the year before last." Another staff member told us, "I had one meeting with [Registered Manager] after I'd been here about six weeks to see how I was settling in, but nothing since." A third member of staff said, "My appraisal last year was cancelled and just never got booked again."

Staff members told us that this had an impact on their own professional development. For example, a number of staff members told us that they struggled with the electronic training system which was in use, but they did not have the opportunity to discuss this or seek alternative ways of training as supervisions were not conducted on a regular basis. Staff told us about their aspirations to develop in their roles, but there were no systems in place to record these goals, or to act on them to help staff. One staff member told us, "I don't have any objectives at the minute." Another told us how they would like to be more involved in people's assessments, but no plan was in place to make this happen.

We discussed these issues with the registered manager and senior quality assurance manager. They acknowledged that this was an area which required development and had identified this during the checks and audits which had been implemented by the new provider. Staff recruitment records showed that regular supervisions and annual appraisals had not taken place. This confirmed that staff were not provided with the opportunity to discuss their development or concerns they had about the service.

Members of staff did not receive appropriate support, opportunities for professional development, supervision and appraisal to enable them to carry out their roles. This was a breach of regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a number of training courses available for members of staff. Staff told us that they were able to complete a range of different training, however; they did tell us that the only training option was electronic courses. One staff member said, "Lots of training is available to us, but it's all online." Another told us, "All the training I've done so far has been online." Staff members went on to explain that this did not always help them to learn and understand the content of the training that was being completed. This meant that the approach to training did not always meet staff members' individual learning styles.

We spoke with the registered manager and the senior quality assurance manager about this. They showed us that they had identified this area of concern and had a plan in place to address this. For example, they planned to use a member of staff from the service who had completed a train-the-trainer qualification to deliver face to face training courses, as well as member of senior staff from the new provider. This would help to ensure that staff training needs were being met. We also saw a training matrix and staff training certificates, which showed that staff members had completed a number of training courses, including safeguarding, manual handling and health and safety.

New staff members received an induction when they started at the service which included training courses and the opportunity to shadow more experienced staff members. One staff member said, "I had the chance to do a few shadowing shifts." Another told us, "They do an induction with all the new staff." We looked at staffing records and the confirmed that new staff members were provided with an induction which included showing them around the service and introducing them to people, as well as shifts where they shadowed experienced staff members to get used to their roles. We also saw that new staff members were enrolled on the Care Certificate to ensure they developed the essential standards they needed to be effective care workers. In addition, vocational qualifications were provided for more established staff, to help them continue to develop their skills.

People's consent to their care, treatment and support had not been clearly demonstrated. We looked in people's care records and found that there was little evidence to show that people had agreed to the arrangements in place for their care, treatment and support. There were not consent forms in place in some care plans, whilst others only showed consent forms for the service to take people's photographs. This meant that we could not be sure that people had provided their consent to the care plans which were in place for them.

The registered manager and the senior quality assurance manager had identified that this was an area which needed to be developed. They told us that there were plans in place to review the format of people's care plans and the documentation used. This would include an improved way of recording people's consent.

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

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

Staff members demonstrated an understanding of the MCA and how it affected their day-to-roles, however; the systems in place for the application of the MCA, particularly for complex decisions, was not robust. Care plans did not always show how people's capacity had been considered when decisions were made on their behalf and there was sufficient evidence to show that a best interests approach had been followed. For example, in one care plan we reviewed we saw that a best interests form was in place regarding the arrangements for a person's care at the end of their life. Sections of this form had not been completed and there was nothing to show what options had been considered, or how they affected the person. In addition, there was nothing to show that their previous views or wishes had been considered, or that their family members had been involved in making the decision.

We did see that the new provider had introduced an improved MCA and best interests process. A more robust MCA assessment form and best interests checklist was available for staff to use in the future, however; we saw that only one of these had been put in place when we visited. The registered manager and senior quality assurance manager assured us that they would be reviewing how the MCA was applied at the service and that the new form would be used routinely for people who were unable to make decisions for

themselves. This meant there was a risk that decisions made about people's care, treatment and support may be made without following a best interests' process.

The systems in place at the service were not sufficient to ensure that care and treatment was provided with the consent of the relevant person. The service had not always acted in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff members sought their consent for decisions on a day-to-day basis. One person told us, "They ask me what I want to have or do, they listen to what I have to say about it." Throughout the inspection we saw that people were offered choices such as what they wanted to eat or where they wanted to spend their time. When people made a decision, staff respected it and worked to ensure their choice was provided.

The registered manager showed us that they had made DoLS applications for those people who were unable to make decisions about living at the service and who were at risk of having their liberty deprived. In these circumstances, the provider had used a more robust approach to assessing people's mental capacity and had taken appropriate action to ensure their liberty was not deprived. There was a tracker in place so that the registered manager could monitor the dates of any DoLS authorisations which were in place, so that they were not allowed to expire. There were suitable arrangements in place for the application of DoLS.

People were happy with the food and drink which was provided by the service. One person told us, "Food is good on the whole, I would say it's on par with how you would cook it yourself at home. There is always plenty to eat and drink." Another person said, "There is a good choice and I'm sure if none of that suited you they would find you something else to eat."

During the inspection we saw that meals were provided in a calm and pleasant environment which was conducive to dining. Meals were served to people individually and appeared appetising and well-portioned. Where people and specific dietary needs, such as requiring soft or pureed food, efforts had been made to ensure this was still attractive and pleasant to eat. Adaptive equipment was available for people to help them eat and staff members also provided people with assistance where required. We saw that people were enjoying their meal times and that snacks and drinks were available for people throughout the day.

We spoke with the chef who showed us that they had a well-stocked kitchen with a range of fresh ingredients. They were aware of the specific needs of people at the service and worked to make sure that they were met. People's care plans also reflected people's dietary needs and showed that the service had monitoring charts in place to review the risk of people become malnourished or to identify, and take action, when weight loss, had happened.

The service worked to ensure people were able to access healthcare professionals when required. One person told us, "They're very good at getting you to the doctors." Another person said, "They take me to see my GP regularly and I see the chiropodist here."

Staff members told us that appointments were made whenever people needed to see a healthcare professional. Appointments could be arranged at the service or in healthcare settings and the service had transport available to help get people to their appointments. We saw that there were referrals to professionals such as GP's, dietitians and district nurses to help ensure that people's needs were being met. The outcomes of appointments were recorded in care plans and staff took action in response to this information to help people be at the best health possible.

Good

Is the service caring?

Our findings

People told us that staff members treated them with kindness and compassion. One person said, "Oh yes, the girls are very caring." Another person told us, "The staff here are very friendly and look after me very well." A third person said, "I can't complain, they are like family to me." Relatives also told us that staff members treated their family members kindly, and made sure they were happy and comfortable in the service. One relative said, "Staff are really caring towards Mum."

There were positive relationships between people and members of staff. People told us that staff were able to spend time talking with them and getting to know all about them. One person said, "The carers are lovely, it's nice at this stage of life to have someone to look after us and they are there to have a little talk with." Another person said, "They always ask if I need any help, they never get tired of chatting to me." Relatives told us they had observed positive relationships developing between their family members and staff at the service. One relative said, "They know he has a sense of humour and always try to bring that out in him."

Staff members also told us that they were able to develop strong relationships with the people living at the service. They told us that they were able to spend time with people, getting to know about them and the care that they needed. Staff members worked together to ensure that useful information was shared within the team, which helped all staff to develop their relationships with people. One new staff member told us, "Other staff have been really helpful in me getting to know people." Another staff member said, "We get to know people, I can tell if there are any changes or if they are not so well."

Throughout the inspection we saw positive interactions between people and members of staff. Staff were kind and gentle when speaking with people and gave them time to think about what they wanted to say. People were not made to feel rushed or a burden on staff and the care provided did not seem focused purely on tasks, but also on the social needs of people. Staff engaged in small talk and conversation and provided people with encouragement or reassurance if required.

People were involved in the service and the way in which it was run. They told us that there was information available to them if they needed it and one person pointed out a notice board to us during the inspection, which displayed useful information about the service and events which were to be taking place. Staff members told us that people were able to access their care plans whenever they wanted and that they were happy to sit with people to go through the content of the plans if they needed support.

Family members told us that the service kept them up-to-date of any developments with the service, or with the care of their relative. They explained that this gave them peace of mind, particularly if they were unable to visit the home on a regular basis. One relative told us, "Any minor issues with Mum, the manager always takes care of it but still informs us."

We saw that useful and important information was displayed throughout the service for people, their family members and members of staff to refer to. This included menus, activity plans and useful contact information. For example, we saw that there was guidance on how to make a complaint internally, as well as

external organisations, such as the Care Quality Commission (CQC) who could also be contacted.

Staff members worked hard to ensure that people were treated with dignity and respect at all times. People told us that they felt their dignity was upheld and that staff were considerate of their privacy at all times. One person said, "Oh yes, they're very respectful." Another person told us, "They are very respectful towards me."

People told us that staff members always listened to what they had to say and respected the choices they made. They also told us that they were encouraged to be as independent as possible, which helped people to feel dignified whilst being cared for. One person said, "I like to have a bath, not a shower, so they always take me and look after me. They always treat me with love and call me by my name." Another person told us, "I like to wash myself, I don't like to give in and they know that. I like to be independent but if I want help I only have to ask. They are genuine in their approach to me and I have never felt unhappy here."

Relatives felt that staff members at the service worked hard to ensure people's dignity and respect was maintained at all times. One relative told us, "My husband is always well-dressed, clean and shaved. That keeps his dignity intact."

Staff members explained that people's privacy and dignity was an important part of their roles and they were mindful to ensure that people were treated in a respectful manner at all times. They also told us that they received training in this area to help remind them of the importance of this. Throughout our inspection we saw that staff were working hard to treat people in a dignified manner. They were discreet when supporting people with personal care and helped to ensure that people's clothing was clean and that they were able to pass their time in the way they wanted to. We saw evidence of staff training in this area and that the provider had a policy for staff to follow.

Part of the policy included receiving visitors. People and their family members confirmed that there were no restrictions on when they could visit the service and there were a number of different communal areas where people could pass time with their families, as well as their own bedrooms where they could also receive visits.

Requires Improvement

Is the service responsive?

Our findings

People did not always benefit from having person-centred arrangements in place for their care, treatment and support. People had care plans in place however; these failed to demonstrate how people had been involved in the production of the plans, and lacked specific information about people's care and support needs and preferences. The service relied on the experience and knowledge of members of staff to ensure people received the care and support they needed.

We reviewed people's care plans and found that they contained basic information about their specific care needs, however; they did not provided staff with information about people's preferences and did not demonstrate that people had been involved in planning their own care. We saw that the provider had implemented personal preference forms to try to introduce some person-centred elements to care plans, however; these were not filled in completely and did not provide staff with important information, such as people's preferences and behavioural traits, as these boxes on the forms had not been completed. This showed the care plans were not effective in ensuring staff were equipped with person-centred information to enable them to provide people with care which was sensitive to their individual needs and preferences.

The care plans which were in place failed to provide staff with guidance about how they should manage people's care and support needs. For example, one person's plan for personal care stated that they may become agitated, however; it did not provide staff with guidance about how they could adapt their approach or what may work to help provide this person with the care that they required. This meant that people's care may not be provided in a consistent, person-centred way as staff members did not have one piece of guidance to follow.

Care plans also failed to show how people had been involved in planning or reviewing their care. There was nothing to show that people had been asked about how they wanted their care and support to be provided and care plans failed to evidence how people's views or opinions had been sought. We saw that care plans had been reviewed on a regular basis by members of staff, but there was nothing to show that changes had been made as a result of these changes, or that people or their family members had been consulted to see if any changes needed to be made to the care plan from their point of view.

Staff members told us that they were aware of people's care plans but explained that they were quite basic in their content. One staff member told us, "Care plans are okay, we just get to know people though." Staff explained that the care plans did not always provide them with specific details of people's preferences or wishes, but they spent time with people and got to know this about them. During the inspection we saw that staff were able to spend time with people and had developed an understanding of each individual person. We found that staff knew people and were able to tell us information about them which was not contained within people's care plans. This meant that new staff members would not have the benefit of this information as it was not recorded anywhere for them to refer to.

The arrangements in place for people's care and treatment was not always reflective of people's individual needs and preferences, which meant that their care was not always person-centred. This was a breach of

Regulation 9 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

People told us that they felt staff at the service were responsive to their needs and treated them the way they wanted to be treated. One person told us, "Yes I do think they get to know us and our needs." Another person said, "I think they know me very well."

We spoke with the registered manager and the senior quality assurance manager about care planning at the service. They explained that there were plans in place to move care records over to an electronic system, which would enable more robust records to be maintained. They also told us that part of the process of moving over to this system would include updating people's current care plans and records to ensure they were person-centred and contained specific information about people's needs and preferences.

The service had an activities programme in place to ensure people had the opportunity to keep busy and stimulate their minds, which was headed by an activities coordinator. People were generally positive about the activities on offer, however; people and staff told us that it was a stretch for one person to provide activities for everybody. One person told us, "[Name of staff member] takes us on trips; I really like that." Another person said, "I know there are activities in the lounge. I do go sometimes but I have a lot of visitors, but what's nice is just being able to please myself." Relatives were also aware of the activities which were available at the service. One relative said, "They do try to encourage her to go down for activities in the main lounge."

Staff members explained that all staff were able to spend time talking and engaging with people and the activity coordinator took the lead with planned activities. These included games in communal areas, visiting entertainers including singers and trips into the local community in the services' minibus. Staff were positive about the range of activities they were able to provide, however; they told us that it was difficult to ensure everybody had the opportunity to do something. For example, if the activity coordinator took a group of people into the community, there was often not enough staff or resources left at the service to provide those that remained activities or things to do.

We discussed the activity provision at the service with the registered manager and the senior quality assurance manager. They agreed that there were a lot of people for one activities coordinator to get around, and acknowledged that when they were not at the service, there were no specific activities on offer. They told us that they would review this and identify ways in which this could be improved in the future.

There were systems in place to receive and act on feedback, including complaints, received by the service. People told us they were aware of how to raise complaints if they were not happy with anything and felt that their concerns would be taken seriously. One person said, "I've nothing to complain about." Another told us, "I can't fault them, I have never complained but if I had any I would tell my daughter to deal with it." Relatives told us they were happy with the care provided by the service but they could raise concerns if necessary and things would be put right.

The registered manager showed us that the service had a complaints policy in place. This provided the procedure to follow if people wanted to make complaints and set out how complaints would be dealt with. We saw that any complaints which had been made had been logged and appropriate action had been taken in response to issues raised. We also saw that the service had received positive feedback and thank you notes from people and their family members, which was shared with the staff team.

There was a system in place to request feedback from people and their family members about the care received at the service. An annual survey was carried out to monitor people's opinions about a number of

different elements of their care. We saw that the results of these surveys were collated and reviewed and were used to learn lessons and help guide future improvements at the service.

Requires Improvement

Is the service well-led?

Our findings

There was not always a positive culture among staff members working at the service. Staff members were positive about their roles and the people they were supporting, however; they explained that the service was going through a period of transition as the new provider took over. This had a de-stabilising impact on members of staff and they were left feeling uneasy about the changes taking place. One staff member said, "There's been lots of changes with the new providers. Lots of different faces and visitors, not sure who they all are." Another staff member said, "All the new faces and visitors have been disruptive." A third staff member said, "We all need to know where we stand with the new owners really and what changes are going to be made. We're in the dark a bit at the moment."

Staff members did say they felt the new provider would bring additional support for the registered manager and the service, which would have a positive impact in the long term. One staff member said, "The new providers have more support coming in." Another told us, "There seems to be more support now." This had helped to maintain a positive ethos in the staff team. They were positive about the role they performed and were motivated to provide people with the care and support they needed.

All of the staff we spoke with were clear about how to report any concerns about people's safety or wellbeing. They were all prepared to approach the manager with these concerns and also told us that they were willing to report directly to external organisations, such as the Care Quality Commission (CQC) if they felt their concerns were not responded to appropriately.

We spoke with the registered manager and the senior quality assurance manager about how staff members were feeling. They told us that they were aware that there was some unease amongst staff members which was having an impact on the culture at the service. They told us that they were starting to address this issue and were working to reassure staff and provide them with the support they needed to perform their roles. For example, during our visit there was a human resources manager who made themselves available throughout the day to talk with staff on a one on one basis to discuss any concerns they may have. Both the registered manager and senior quality assurance manager felt this had been a worthwhile exercise for staff and would explore further opportunities to support staff in the future.

There were quality assurance systems in place at the service, however; these had not always been effective at identifying areas which needed to be reviewed and improved. We saw that previously completed checks and audits had not always highlighted the fact that there were areas in need of improvement. For example, it had not been previously noted that care plans lacked person-centred information, or that the Mental Capacity Act 2005 had not been robustly applied.

The registered manager however; showed us that the new provider had implemented a wide range of quality assurance processes, designed to help identify areas of the service in which changes were required. We saw that there were a number of checks in place now, including audits such as care plans, medication and infection control. We also saw that there was a clear schedule in place to help ensure each audit was completed in accordance with the provider's policy, as well as guidance notes to support the completion of

each audit. We saw that the registered manager had started to implement these checks and that action plans were being drawn up to show how the concerns raised were going to be managed. We found that a number of the concerns raised during our inspection had been identified during this process, which demonstrated that the new quality assurance procedures would have a positive impact on the development of the service.

The provider also conducted external and audits of the service. The senior quality assurance manager told us that they carried out checks at the service to help ensure nothing was missed and to help drive improvements at the service. We saw that these checks were carried out in conjunction with those at the service to help develop the service.

People were positive about the registered manager and felt they were approachable and available when they needed them. One person told us, "Yes I know who the manager is; I can talk to her if I need to." Another person said, "She's lovely, very easy to talk to." People we spoke with were able to tell us who the manager was and how they would be able to get hold of them if they needed them. Relatives were also positive about the registered manager. One relative told us, "We have a very good relationship with the manager, she is amazing; very approachable."

Staff members told us that the felt the registered manager was usually very supportive, however; recently they had not been as visible a presence at the service. Staff explained that they felt this was due to the changes being implemented by the new provider, which had consumed a lot of the registered manager's time and made them less accessible. One staff member said, "She's usually not bad at all, but lately she has been very busy." We discussed this with the registered manager and the senior quality assurance manager. They acknowledged that the registered manager had been working hard recently to ensure the new changes, such as additional audits and checks, were implemented and that this may have had an impact on the support they could offer to staff. Both were committed to finding a way to ensure that staff members received the support they needed in the future.

We found that the registered manager had taken steps to ensure they were meeting their regulatory obligations. They were overseeing and reviewing incidents and accidents at the service and making sure external organisations, such as local authority safeguarding teams, were notified appropriately. We checked and found that they had submitted statutory notifications to the CQC about important events, such as safeguarding incidents, as was required of them by legal regulations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The arrangements in place for people's care and treatment was not always reflective of people's individual needs and preferences, which meant that their care was not always person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The systems in place at the service were not sufficient to ensure that care and treatment was provided with the consent of the relevant person. The service had not always acted in accordance with the Mental Capacity Act 2005.

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 Members of staff did not receive appropriate support, opportunities for professional development, supervision and appraisal to enable them to carry out their roles.