

Bupa Care Homes Limited

Ryland View Care Home

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?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 12 and 13 September 2017 and was an unannounced inspection.

Ryland View Care Home was previously registered under the provider name of BUPA Care Homes (CFH Care Limited) up until February 2017. We were notified in December 2016 that the provider intended to simplify its structure and applied for all of its registered locations across the UK, (which at that time were registered across 13 different legal entities) to transfer over to just two legal entities. This meant that Ryland View Care Home became newly registered under the provider name Bupa Care Homes Limited in February 2017. Therefore, this was the provider's first inspection at this location since newly registering with us in February 2017. The inspection history for the location under the previous provider was used to inform the planning of this inspection because there had been no other changes at the location; the registered manager and the running of the service had remained consistent.

Our last comprehensive inspection of this location took place in January 2016; the service was rated as Good. The report from this inspection is available in the full history of inspection reports, which can be found in the previous provider's archived records for this location on our website at www.cqc.org.uk.

Ryland View Care Home provides accommodation and nursing care for up to 144 people. At the time of our inspection, there were 144 people living at the home. Care was provided within five units. Bloomfield and Heronville units provided care to people who lived with dementia, whilst Palethorpe unit provided care to younger adults who lived with a physical disability. Haines unit provided care to people who lived with conditions and frailty relating to old age. Manby unit facilitated intermediate and step down support and care for people for a short duration of time; some people on this unit had been discharged from hospital and required short term support to regain their health and/or mobility.

There was a registered manager [RM] in post. 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. On the day of our inspection the RM was not available so we were supported by the acting manager in the RMs absence [also a unit manager] and the Regional Director.

Medicines administered to people in food or drink or via a tube to their stomach did not have all of the necessary safeguards and guidance for staff in place. Some medicines used for pain relief had been administered beyond their expiry date. Medicines administration records clearly demonstrated that people were receiving their medicines at the times they needed them.

Risks to people in relation to the support they required to maintain their health had been assessed; however these had not been consistently monitored on all units in relation to the equipment in use for supporting

and maintaining skin health.

People felt safe living at the home because staff supported them well with their health care needs. The provider ensured enough staff were on duty to ensure their needs were met in a timely manner and reviewed staffing levels on a daily basis. The provider operated safe recruitment practices, ensuring the necessary pre-employment checks were carried out.

The provider had identified some staff as 'safeguarding champions' who had received advanced training in this area to act as an additional source of support and information for other staff. The provider operated clear processes and had a policy in relation to the reporting and learning from incidents. Staff understood how they should respond to a range of potential emergencies.

The oversight and application of the Mental Capacity Act [MCA] and Deprivation of Liberties Safeguards [DoLS] was in need of review at the home. Staff understanding of DoLS was variable. Staff established consent from people before providing care.

Resuscitation issues were discussed with people or their representative and the appropriate documentation was completed. The staff team were well trained and the provider ensured staff were supported in keeping their knowledge and skills updated. New staff were provided with a structured induction. People were provided with choices of food and drink that met their needs and preferences. People were supported to access all the health care support they needed in order to maintain their wellbeing.

People's right to privacy was protected and they were treated with dignity and respect. Staff demonstrated they were kind and compassionate when meeting people's needs. People and/or their representatives were involved in the planning of their care wherever possible.

Communication within the service was effective and staff used a variety of methods of communication to establish people's requests and ensure their understanding. A broad range of activities were available and events took place that people enjoyed and engaged in.

Regular meetings and discussions took place to review and respond accordingly to people's changing needs. Clear information about the service, the facilities, and how to complain was made available to people. Complaints received were fully investigated and responded to.

Peoples' feedback was actively sought, encouraged and acted upon. People were overwhelmingly positive about the service they received. Staff were clear about the leadership structure within the home and were fully involved and updated in relation to its development.

Audits were carried out about every aspect of the service to identify how it could improve and monitor its effectiveness; however we found some deficits that these quality checks had not identified. When the need for improvement was identified, remedial action was taken to improve the quality of the service. A variety of regular staff and senior management meetings took place to share and review updates about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Medicines administered to people in food or drink or via a tube to their stomach did not have all of the necessary safeguards and guidance in place.

Risks to people in relation to the support they required to maintain healthy skin were not monitored effectively across all units.

People had sufficient staff available to support them in a timely manner.

Requires Improvement ●

Is the service effective?

The service was not consistently effective.

The oversight and application of the Mental Capacity Act [MCA] and Deprivation of Liberties Safeguards [DoLS] was in need of review at the home.

Resuscitation issues were discussed with people or their representative and the appropriate documentation was completed.

People were supported to access the health care support they needed in order to maintain their wellbeing.

Requires Improvement ●

Is the service caring?

The service was caring.

People's right to privacy was protected and they were treated with dignity and respect.

People and/or their representatives were involved in the planning of their care wherever possible.

Staff used a variety of methods of communication to establish people's requests and ensure their understanding.

Good ●

Is the service responsive?

The service was responsive.

A broad range of activities were available and events took place that people enjoyed and engaged in.

Regular meetings and discussions took place to review and respond accordingly to people's changing needs.

Complaints received were fully investigated and responded to.

Good 

Is the service well-led?

The service was not consistently well-led.

Audits were carried out about every aspect of the service; however we found some deficits that these quality checks had not identified.

Peoples' feedback was actively sought, encouraged and acted upon.

A variety of regular staff and senior management meetings took place to share and review updates about the service.

Requires Improvement 

Ryland View 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 unannounced inspection took place on 12 and 13 September 2017. The inspection was conducted by four inspectors, a pharmacy inspector, a specialist advisor and two experts by experience [one on each day of the inspection]. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Experts by Experience involved in this inspection had experience of caring for an older relative who used regulated services including care homes with nursing. A Specialist Advisor is a person who has specialist skills, knowledge and clinical experience in an area of practice relevant to the service being inspected; they are deployed by the Care Quality Commission to support the inspection process. The Specialist Advisor involved in this inspection was a registered nurse with specialist knowledge and skills of nursing people with general and dementia care needs.

We looked at the information that we hold about the service prior to visiting the location. This included notifications from the provider about deaths, incidents and safeguarding alerts which they are required to send us by law. Following our inspection and before the completion of our report we shared concerns with the provider that were raised with us by a whistle-blower. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice or wrongdoing; staff should be supported to raise their concerns within the organisation without fear of reprisal.

A Provider Information Return [PIR] request had not been sent to the provider prior to the inspection and therefore was not available to inform the inspection plans. A PIR is a pre-inspection questionnaire that we send to providers to help us to plan our inspection. It asks providers to give us some key information about the service, what the service does well and any improvements they plan to make.

We contacted the local authority and commissioning services to request their views about the service provided to people at the home, and also consulted Healthwatch. Healthwatch is the independent consumer champion created to listen and gather the public and patient's experiences of using local health

and social care services.

We spoke with 19 people who lived at the home and 14 relatives. We also spoke with 14 members of care and nursing staff, a regional director, five unit managers, the head chef and the head of activities. Some of the people living at the home had complex care needs and were unable to tell us about the service they received. We used a tool called the Short Observational Framework for Inspection (SOFI) on Bloomfield, Palethorpe, Haines and Heronville units coupled with general observations across all the units of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care records of 25 people and examined the medicine administration processes for 21 people and any associated records in detail. We looked at training records for staff and four staff files to review recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including accidents and incident records, compliments, complaints, infection control audits and quality monitoring reports.

Is the service safe?

Our findings

People spoke positively about how the staff managed and provided them with their medicines. They described how staff supported them saying, "The nurse comes and gives me my medication on time", "Nurses give me my medicines without any problems" and "I can't remember all of them [medications taken] but I know if I am in pain I can ask for painkillers and I am given them". A relative said, 'They are so on the ball with [person's name] medication".

We looked at how medicines were managed across three units, Haines, Bloomfield and Palethorpe. We did this by checking the Medicine Administration Records [MAR], speaking to staff and observing how medicines were administered to people. We found where people had to have their medicines administered by disguising them in food or drink the provider did not have all of the necessary safeguards in place to ensure these medicines were administered safely. For example, we found the provider was not able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found that there was no written information to tell staff how to carry out this process safely and consistently. Similarly we found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were administered safely and consistently. We asked one nurse about how they administered medicines directly into the stomach, they said, "There is nothing in writing". They told us how they personally prepared and administered the medicines; this differed from what other staff had already told us. They went on to say, "I think that's what other staff do". This meant that the provider did not have clear written protocols to inform staff on how to prepare and administer the medicine to ensure safety and consistency; in addition they had not taken advice from a pharmacist on whether the written procedures they had in place promoted safe administration.

Medicines were being stored securely and at the correct temperature. Controlled Drugs were stored correctly and their administration was recorded accurately showing that these medicines were being administered as prescribed. Controlled drugs [CD] are a group of medicines which are subject to strict legislative controls due to their potential for abuse and harm. In relation to controlled drugs [CD], we found some medicines stored in the CD cabinet had exceeded their expiry/disposal date. Two of these medicines were analgesic solutions, which had to be discarded three months after first opening. The nursing staff were not aware of this and as a consequence one person received four doses after their solution had expired and another person received three doses after their solution had expired. We spoke to one person who received these medicines who told us they had been finding their pain relief effective and although we were unable to speak with the other person, we could not identify any indication of unmanaged pain in their care records; so no impact had been felt by people of using these expired medicines.

We found the analgesic skin patches were being changed after the prescribed time interval and were being rotated correctly around the body so that people did not experience unnecessary side effects. We found the Medicine Administration Records [MAR] were well completed and demonstrated that people were receiving their medicines at the times they needed them. We observed members of the nursing staff supporting people to take their medicines and saw this was done with kindness, patience and care. In addition safe

administration procedures were used and nursing staff were keen to ensure people's pain was well controlled and effectively managed. We noted that ten members of nursing staff responsible for providing people with medicines had either not yet completed or required an update in the providers advanced medicines training. We raised this with the Regional Director who agreed this needed to be addressed and immediately booked training dates for those staff to complete within the next following weeks.

Risks to people in relation to the support they required to maintain their health and well-being had been considered and assessed. Staff spoken with were clear about people's individual risks and how these should be managed. Staff members told us how they managed risks day to day, saying, "I manage any risks of falls by following the risk assessment, or putting equipment into place like a low bed and putting crash mats by people's beds", "One gentleman really dislikes being moved using the hoist but it is the only way we can do it, so we use three staff to give him maximum support" and "If I found someone on the floor, I would make the person comfortable and alert the nurse, who would check the person over; I would never move someone until it's safe to do so". A nurse told us, "Noise can be a trigger for [person's name] to become upset or agitated so if the environment is noisy we will encourage and support them to move". On Bloomfield we observed how staff dealt with an incident where a person had become agitated; the staff handled this sensitively and appropriately, which reassured the person and helped to diffuse the situation well. We observed people being supported appropriately by staff to use equipment that minimised their risk of falls, for example, walking frames. On Haines unit we observed staff support someone to stand from a seated position. They did this safely and walked alongside the person, with their hand placed on the persons back for reassurance. Staff were heard encouraging the person that she was 'doing well' as they walked along.

Records overall in relation to risks to people were reviewed regularly and/or updated when people's level of risk changed. However the support provided was not consistently checked on all units. For example relating to maintaining healthy skin, we found on Heronville and Bloomfield units that checks in relation to the appropriate settings on the pressure mattresses in use were not being completed by staff, but they were on Palethorpe unit. On Heronville unit our findings were that four out of five pressure mattresses were on the wrong setting in relation to the persons assessed needs. On Bloomfield unit we found a further setting to be on the incorrect setting and a broken dial on another pressure mattress; this was still being used and staff told us they were continuing to use this by estimating the approximate setting. This meant that people were at risk of not receiving the correct pressure relief and support from the equipment in use, putting them at potential risk of developing or worsening pressure areas on their skin.

People and relatives we spoke with across all the units told us that the staff supported them well with their health care needs and that they felt safe living at the home. Peoples comments included, "I feel safe, there's always carer's and nurses around and there's the emergency buzzer if I need it", "I use a hoist and two staff to help me, I feel safe because they take their time", "There are staff around all the while; everybody looks after me", "I feel safe my husband comes every day and the girls [staff] look after me. They [staff] pop in every hour, which makes me feel safe" and "I feel safe, I even have a set of keys so I can lock my door if I wish". A relative said, "People are safe here, the staff are great and very patient".

People told us there were enough staff on duty to ensure their needs were met in a timely manner. They said that staff were responsive to them and they only ever had to wait a few minutes for staff to arrive if they had used their call bell/buzzer. People's comments included, "The staff are always around and always happy. If I need staff at night, they do come", "If I call on them for anything they [staff] are here quickly, they are golden", "It depends on where they are, if they are down the other end [of the corridor or lounge] you will be hanging on, but only for a few minutes", "In about five minutes they will come and see me, there are enough staff on duty" and "I don't use my call bell but a lady along from me does and they [staff] always go to her quickly". We observed there were adequate amounts of staff on duty to meet people's needs in a timely

manner.

We discussed with the acting manager how the skill mix and level of staffing was established and although they used a dependency tool they told us they reviewed staffing levels daily and support that people required with the unit managers at the 'take ten meetings'. The service had very little staff turnover and used its own employees taking on extra hours to promote consistency when gaps in the rota or sickness occurred, before using agency staff. Staff spoke positively about the staffing levels on the units and of recent increases in nurses on duty. Staff members said, "Yes there are enough staff, it does get busy but I am never rushed", "You have good and bad days but nine times out of ten we have enough staff. If we are short we tend to cover it ourselves", "Our staffing has been increased recently and that's been a big help. We used to only have one nurse on the unit and now it's two" and "We are quite lucky in terms of staffing levels".

The provider operated safe recruitment practices. We found that the necessary pre-employment checks were carried out. These included the obtaining of references and checks with the Disclosure and Barring Service [DBS]. The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concerns. We also saw that checks for nursing staff were undertaken with the Nursing and Midwifery Council (NMC), which confirmed that the nurses were eligible and safe to practice. This meant that people had assurance that only suitable staff would be employed to work at the home. We had experience of how the provider operated their disciplinary procedures following an incident that occurred at the home prior to our inspection and found their processes to be robust.

People spoken with told us they had not experienced any kind of abuse whilst living at the home. Two people told us, "I've never been mistreated" and "Abuse? No staff are all very kind to me". Staff we spoke with on all five units were knowledgeable about the potential risks of abuse and avoidable harm and were aware of what their roles and responsibilities were in relation to reporting any concerns. The staff spoken with said, "I would tell my line manager if I thought there was abuse and if nothing happened, I would take it higher", "I have had safeguarding training. I would immediately inform the unit manager if I had a concern and then they would do their part" and "Abuse can come in all forms, physical, sexual, basically anything that causes a person distress, I would raise any concerns I had with the unit manager" and "If there are any safeguarding issues we discuss these and [unit managers name] gives us feedback about any actions". We saw that some members of staff were identified as 'safeguarding champions' as they had undertaken more detailed and advanced training; this meant that staff could seek their advice and support in relation to any concerns, alongside the usual routes available to them. The Regional Director informed us that a number of other staff had signed up to undertake the advanced training in safeguarding provided by a local college.

The provider operated clear processes and had a policy in relation to the reporting and learning from incidents. Staff we spoke with were clear about the processes for responding to and reporting incidents. They told us they were kept informed in meetings about the outcomes in relation to incidents they were involved in and those that occurred within other units where learning or changes to practice were adopted. Updates were given and actions taken or to be completed were reviewed in relevant senior management meetings. This demonstrated that the provider was keen to learn from incidents and maximise the safety of people using the service.

We reviewed the maintenance records and environmental checks undertaken by the provider and saw that for example, servicing of equipment, fire systems and boilers were effectively managed. Audits were undertaken to make sure all equipment was serviced and the environment was checked for safety as required. Feedback about any actions outstanding or completed in relation to health and safety was recorded and reported back to senior management on a regular basis. Staff understood how they should

respond to a range of different emergencies. We saw that they took part in regular fire drills which helped them to remember the correct procedures; we saw there was appropriate signage about exits and fire equipment on all the units.

Is the service effective?

Our findings

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.

People told us staff sought their consent, one person told us, and "They [staff] ask for my permission and always give me choices". Staff knowledge in relation to MCA and DoLS was varied. Examples of staff responses we received included, "I have done training in MCA a few years ago I think, but I will be honest, I don't know what MCA or DoLS is. I don't think anyone here has a DoLS in place but I'm not sure", "I have done MCA training; it's to do with people lacking capacity", "I did training in mental capacity. We assess if a person has capacity to make decisions. If someone doesn't have capacity we go to best interests with multidisciplinary team and family. Then we would go to DoLS if needed" and "I have had training in DoLS a long time ago, it's when someone acts as an advocate for a person because they have no family". This was also our finding at our last inspection in January 2016, which meant that this area had not shown the anticipated improvements in the whole staff team level of understanding.

We observed that a person on Palethorpe unit had a number of restrictions in place which needed to be further considered by an application to the supervisory body; the unit manager confirmed that this had not been actioned. Another person on the unit had an application submitted in 2015 but no evidence of the outcome of this was available and/or whether it had been appropriately followed up by the provider. On other units we found that overall the application of DoLS was well managed. On Bloomfield unit we found that walking frames were not within reaching distance of people sitting in chairs in the lounge, which meant they were restricted from mobilising around the unit if they so wished. We asked a nurse on the unit about this practice and they told us, "A lot of people here are at risk of falls so this prevents them walking unassisted and falling". So although essentially staff were acting in peoples best interests this had not been formally agreed with them or their representatives. We shared our concerns with the management team on day one and these issues had been remedied on our return on day two; this included any necessary applications in relation to identified restrictions to the supervisory body in this instance the local authority. We spoke to the unit manager on Bloomfield who described identifying people that needed applications for DoLS to be made due to any identified potential restrictions as a 'work in progress'. Where people were deemed to lack the mental capacity to consent, we saw in the majority applications to deprive the person of their liberty within their best interests had been sent and authorised. The providers own records related to mental capacity assessments and best interests' decisions on the whole clearly evidenced the process used, and were specific to the element of support being considered.

We reviewed the documentation in relation to people's decisions about resuscitation known as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and found these were completed to a good standard. In line with best practice they had been completed with the person's knowledge, participation and agreement where possible, or alternatively their designated representative.

People and their relatives all spoke positively about the support they received from staff and were confident that they staff were well trained. Peoples comments in relation to staff competence included, "I know they are well trained because they can always do what I ask and need them to", "Oh yes they [staff] know what they are doing, they have a look at me first and assess me if I am not well and then ring the doctor if they think I need them" and "They [staff] look after you well".

Staff we spoke with described a culture of learning and said the provider actively encouraged and supported them to develop their knowledge and skills. One nurse told us, "Our clinical training goes on all the time. We look at medication, resuscitation practice, care planning and we get sent for training to help our nurse revalidation. It is everything that I need and [unit manager's name] always stresses to us to ask for more training if we want it". Other staff members commented on the quality and availability of the training they received stating, "The training good, we learn something new every time. I have recently done moving and handling, safeguarding and I have nutrition training tomorrow", "The training is good and we can ask for extra. I am a member of the Royal College of Nursing [RCN] and also enrol myself on their training courses, they [the provider] support me and give me the day off so I can attend". One staff member spoke about the benefits and learning from the dementia training they had received called 'Person First', they said, "Its good training, it puts you in people's shoes who have dementia and gives you a better understanding of how they can be affected by how we approach their care". Staff told us they received reminders and memos about what training was due or needed refreshing that they needed to complete. Records we reviewed showed that staff were up to date with their basic/essential training and from our discussions it was clear that ongoing learning opportunities were made available to them by the provider.

Staff we spoke with told us that they had received a thorough and robust induction programme when they first joined the service. One member of staff told us, "The induction was doing all of the training and we had a new starter pack that needed to be completed. I shadowed a senior member of staff for two days. The induction was good and there was always someone to ask if I was unsure of anything". We saw that the provider had implemented the Care Certificate. The Care Certificate is a set of standards designed to equip staff with the knowledge they need to provide people's care. All the staff we spoke with told us that they felt supported in their role on a day to day basis and through structured supervision and their annual appraisal. Staff members told us, "In supervisions we discuss our personal development" and "The managers don't overlook you and want to know how you are doing in your job; they want us to be the best so we are on the ball" and "We have regular supervision and meetings".

People gave us positive comments about the quality, choice of food and drinks available to them. Comments from people included ""The food is good here, there's plenty of choice, with a cooked breakfast on offer if you want one", "If you don't like it they [staff] take it back [meal] and give you something else" and "We have plenty of drinks provided all day long". We saw one person's request for takeaway food at lunchtime was catered for, the person told us, "The staff are bang on, they do offer me other things and ask what I want [to eat]. I've been having takeaways instead of the meals here but that's my choice". We observed lunch being provided on all the units and found this to be a relaxed and supportive event. People were being given choices, for example we heard people being asked if they would like any salt, pepper or sauce with their food. People were observed being helped where needed to eat and drink by staff that were patient and allowed the person to take their time, asking if they were ready before supporting with next forkful. One staff member said, "Anyone at risk of choking is monitored closely at meal times". Staff

were observed to be flexible in their approach in supporting people to eat and drink; for example we saw staff swapping places with other staff to support individuals to try to get them to eat more successfully, for one person on Bloomfield Unit this was effective. A variety of foods that met people's cultural needs was on offer, for example meals on the menu for people who do not eat pork or beef as part of their religious beliefs. We saw people were supported to remain as independent as possible with their eating through the use of specialised cutlery and plate guards. On Manby Unit there was a 'meal comment diary' where people were able to anonymously leave feedback on food. We saw this had been used recently where someone complained that the apple crumble had too much topping. The unit manager told us that the feedback is shared at the 'heads of' meeting' and any necessary action taken.

A staff member explained that people's dietary needs were written on the menu so that when staff were serving food, they could also see at a glance who had specific dietary needs. One staff member said, "We meet the dietary needs of people who are diabetic by ensuring the kitchen staff have the details of their diet. We encourage healthy eating, check peoples blood sugars and review their diets where needed and inform the doctor of any concerns". People's weight was monitored and recorded and action was taken to support people to maintain a healthy weight where required, for example where weight loss was an issue, through the introduction of a fortified diet. Staff told us how they supported people to enjoy the food they liked, one staff member said, "The kitchen staff are really flexible; relatives have been invited in to show the chef exactly how to cook their loved ones favourite meals".

People we spoke with told us that staff supported them to access other health care services when needed that included the dentist and chiropodist. A staff member said, "The physiotherapist comes and the staff always carry on the exercises too. We link them to the activities so they people can have fun at the same time". Another staff member said, "People all get regular visits from the opticians and dentists as well as annual health checks". Records we looked at showed that people were supported in relation to any changing or complex needs and any health care concerns were followed up in a timely manner with referrals to the relevant services. For example, where risks had been identified regarding weight loss or difficulty in swallowing, referrals had been made to the appropriate external healthcare professionals [HCP] for advice. Any recommendations made by HCP were recorded in people's care records and staff we spoke with were aware of these. This meant that people were supported to maintain good health.

Is the service caring?

Our findings

People and relatives we spoke with were complimentary about the care and support they received. Their comments about the staff and care they received included, "The service is very good, the staff are very understanding and the carer's are marvellous", "I have been here for a few days, they are lovely here, very nice" and "You wouldn't get better staff than these, they look after you lovely". A relative spoke with described how supported they and their family had been when their loved one first arrived at the home. They told us, "They [staff] encouraged my [relative] to stay all day to help [person's name] settle in and even provided them with meals" and went on to say that this has continued and that staff encourage [relative] to spend as much time there with them as they liked. Other relatives were keen to tell us how caring staff were including such comments as, "The staff who look after her are so good", "Staff are good, always a smile on their face, very helpful" and "We are very pleased they [staff] go beyond caring, they are all golden". We spoke to one unit manager who was organising the funeral of a person who had no family; it was clear to us they were noticeably moved and saddened by this. They planned to meet with staff on the two units where the person spent most of their stay, to ask staff their thoughts on what the person liked before returning to the funeral directors. This further demonstrated to us that staff developed caring relationships with people who used the service.

All of the units had a homely feel and we saw that communal areas had a social atmosphere where people were encouraged to chat if they wished or join in activities; whilst people's need for privacy and quiet was also seen to be supported. One person spoken with described the atmosphere as, 'very caring and very happy'. We saw people smiling and laughing with staff and when a person showed signs of distress, they were reassured by staff contact. It was clear that positive friendly relationships had been developed between the staff and people as well as with relatives and visitors. A relative told us, "I feel like they [staff] have looked after all of us [family]. They are so supportive". Staff were smiling and engaging with people well; they stopped to listen to people and responded to them with apparent interest. We saw all the staff approached people in a friendly and caring manner, demonstrating calmness in their approach. They followed peoples' pace when they helped them and when they conversed with them.

People were encouraged to express their views and be actively involved in making decisions about their care, treatment and support. They told us, "If I want to go to bed now they [staff] will take me up. I am always able to choose what I wear", "I choose what I do and what I want to wear" and "Well they [staff] know what I want and when I need it. It's like if I don't feel well and I want to go to bed they just put me in bed". We found that people received their care and support from staff who knew their preferences well due to consistency of the staff team in place. We saw that many females wore items of jewellery and had their nails manicured and painted with staff support. A staff member said, "I know how important the little touches are to some of the people here; you see how much happier they seem if they have their jewellery and make up on or a splash of aftershave and their favourite clothes on". We saw that people were smartly dressed, had their hair well- groomed/styled and the men were clean shaven. This met people's individual preferences and promoted their self-esteem whilst acknowledging their individuality.

People told us they felt informed about their treatment and care and staff gave them the information and

explanations that they needed. One person shared, "They [staff] did tell me everything I needed to know when I came here". A relative told us about how informed they felt when their relative was able to go back home, they told us "When [person's name] was discharged the information given to me by the staff was very thorough and I was very confident that I had been told everything I needed to know". Their relative been discharged from the unit previously but was readmitted a short time later at their own request.

We saw that a variety of methods of communication were employed to establish peoples understanding, for example to support people with a sensory impairment or dementia. Staff we spoke with described the ways they communicated and consulted with people and their families to have all the information they needed, both verbally and supported with written care records and information leaflets. We discussed the ways staff communicated effectively with people, they told us, "If someone can't communicate then I use flash cards", "I seek consent verbally or if they cannot verbalise, I would use sign language or write things down" and "We have people who do not speak English. We communicate with them by using communication cards provided by family. There are also staff who speak the same language who can help". We observed how staff supported one person with communication as they had limited English through the use of a folder with questions written in English and the translation underneath to aid communication. Examples we noted included, do you want breakfast and are you hungry as well as more common phrases such as 'good morning' and 'hello'; we saw this was effective in establishing the person's needs. Information was displayed for people and relatives on communication boards including dates of relatives meetings and other upcoming events/outings. Pictorial signs were seen around the service for bathrooms/toilets, names were displayed on doors and memory boxes were set up outside people's rooms supported people with memory problems to identify their room on Bloomfield unit. However on Heronville unit these were not displayed on all rooms. We also saw that people were supported to keep up to date with local news through the use of 'Sandwell Talking News' which was an audio service of local news. The activities coordinator received an updated memory stick each fortnight through the scheme, they told us, "People listen to it in their rooms, they love it, it's very useful and full of interesting facts".

We observed that personal care was offered and provided discreetly by staff to people. People told us staff respected them and provided dignified care, their comments included, "Staff knock the door", "The staff knock on doors and wait until I tell them to come in" and "They leave me alone and give me space when I tell them to". Staff demonstrated a good understanding of the balance between maintaining people's privacy whilst also acknowledging the need to monitor their well-being. For example we saw a member of staff waiting in the hallway, who explained to us that they had supported someone to the toilet opposite and was giving them some privacy. We later saw the staff member go to the toilet shortly after, knock the door and ask if the person would like or needed any help. A staff member told us, "I always put a towel on the person, wash them stage by stage so there are not exposed too much and we keep their dignity". People confirmed they had their independence maintained in the way their care was provided. A person told us, "I wash and dress myself generally but if I need help anytime the staff are here for me". We saw examples of this throughout the inspection, for example we saw staff supporting people to mobilise and remain as active as possible.

For those people who did not have a family member or carer who was appropriate to support them to make decisions, staff knew how to access advocacy support. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes.

Is the service responsive?

Our findings

People, relatives and records confirmed that prior to people moving into the home an assessment of their needs was carried out with the person and/or their representative. This enabled staff to ensure people's individual needs and personal preferences could be met at the home. One relative told us how they had visited the home prior to their family member moving in and that a discussion took place around their relative's preferences. Another relative said, "We came to visit Manby unit, the unit manager was very good and she showed us round, the staff seemed very switched on about [person's name] health needs which gave us confidence. I remember a discussion about [person's name] preferences".

People's care and support was planned in partnership with them or their representatives, through both formal meetings and on a daily basis in all aspects of their care planning. People described to us how they were involved in care planning, telling us, "They [staff] ask me what I want, we talk and they ask me questions", "I am involved in the planning of my care, they ask me all the time" and "I have a review of my care plan next week I think". A relative said, "I am involved in [person's name] care planning and when I can I come in for the meetings".

Care records evidenced that people's changing needs were reviewed and addressed appropriately and updates were shared with staff. The registered manager undertook a meeting each morning known as the 'take ten' meeting, with all the unit managers in attendance. The meeting supported the home as a whole to identify high risk people and any changing needs they had for example, any infection or illness they may have developed and planning any action that needed to be taken. This also included identifying the 'resident of the day' which is the scheme the provider operated where each month, one person on each of the units had all aspects of their care reviewed. This involved staff meeting with people and/or their representatives to ensure that they were happy with all the care provided and whether any changes needed to be implemented. Following these discussions, staff would then review and update all of their care records and make sure any other changes highlighted were addressed. A member of staff told us, "Our care records are reviewed every four weeks or as and when changes are needed. We let all the team know about any changes at our handover at the start of each shift. The team are good here and quick to tell us if there are any changes we need to review". This meant there were established systems in place to regularly assess, review and record people's changing needs.

We saw that people and/or their representatives had been involved in completing a document called 'my day, my life, my portrait'. These documents included information about a person's life experiences, interests, likes, dislikes, needs and preferences. In most of these records we saw a good level of detail for example in one record it included what brand of toiletries the person preferred. People were complimentary about how staff supported and understood their preferences, saying "The staff know me, they help me, they know how much I love a bath", "I know all the staff here, some of them have been here since it opened, so they know my needs really well" and "If they [staff] see particular food I like on the trolley they will say [person's name] will have some of that, the staff know me well". Relatives spoken with agreed that staff had a good understanding of what their loved one likes, they told us, "[Person's name] says all the staff are nice and seem to know people's preferences" and "If I have any questions, I know I can ask anything and they all

absolutely know [person's name] needs". We observed the staff provided personalised care to people, understood their emotional and physical needs and always offered them choices. Care plans seen were personalised to each individual and their needs. A staff member said, "When we need to we do ask relatives about what activities the person has enjoyed in the past".

People were supported to follow their interests and take part in social activities. During our inspection we saw a wide range of group and individual activities were being enjoyed by many people. One person described how they remain an avid football supporter of a local team saying, "I go out when I want. I go to the football, I have a season ticket and one of the staff comes with me". Another person told us how they were supported to stay active even with some physical limitations they had, they told us, "I don't take part in the exercises as I have problems but then they give me other gentle things to do". One relative we spoke with told us how impressed they were with the types of activity their relative had been involved in, saying, "[Persons name] does so many different activities. I came yesterday and she was playing darts". They went on to explain that their relative had never played darts in their life before but had won and couldn't stop talking about it afterwards as they had enjoyed it so much. Another relative told us, "[Activities coordinators name] is really good at organising things; there's always something going on, we've [person and their relative] been on lots of outings and they have fetes here". A third relative said, "The staff take an interest in you when you walk in and there is always some type of activity going on".

We saw that each unit had a very pleasant garden area with chairs and tables. In communal lounges people were seated together in small groups to stimulate conversation and avoid any sense of isolation. We saw that there were bird feeding stations outside windows which people could easily see, which were filled up; staff told us these were frequently visited by birds which people liked to watch. On two of the units they had pets, Bloomfield had a budgie and Heronville had chickens. The activities coordinator told us how much people enjoyed seeing and stroking the chickens; it was clear they were handled regularly and used to being around people. We saw that people on Heronville and Bloomfield units were occupied with items such as 'twiddle muffs' [a knitted band that we can attach items to that a person with dementia can twiddle in their hands] or therapy dolls or were receiving more individual attention, such as nail painting.

There was a coffee lounge on Bloomfield unit which was open twice a week and run by two volunteers. Sessions were organised for people who may benefit from meeting and talking with an Admiral Nurse. Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia. People, relatives and staff were able to buy food and enjoy tea and cakes and have a chance to chat together; it had a lovely relaxed atmosphere and we were told it was well attended and often used for people's special birthdays.

The provider actively sought information from people about their individual needs, for example in relation to their sexuality, beliefs or culture as part of personalised care planning. Wherever possible we saw they were supporting these individualised needs. A staff member said, "I am not aware of any one who is LGBT [lesbian, gay, bisexual, and transgender] but we will always try and meet any needs people have and find out how they would like to be supported". People's sexuality was explored including how they expressed this within a 'lifestyle questionnaire'. We saw that people's preference for gender of staff supporting them were met.

All the people we spoke with across the home said they had seen information about how to make a complaint and knew how to raise any concerns they had. People told us, "I can speak to any of the staff if I had a problem but I have never had too", "I would complain to [unit manager's name] if I needed too" and "I would tell my son and he would see the management and they would look into it for me. I have never had reason to complain before". Relatives spoken with also knew how to complain, they said, "I have absolutely

no concerns; I'd be the first to complain if there was" and "I know who to contact if I am worried, nothings one hundred percent but if I raise anything it's dealt with quickly". Staff we spoke with were aware of the ways in which people could raise concerns and complaints and described to us how they would support people to do so. Staff spoken with told us they believed management dealt with all complaints as quickly as possible.

The provider had a complaints procedure in place and we were told by unit managers and staff that people were encouraged to raise any concerns at any time. All formal complaints we reviewed were recorded and investigated with records being well maintained and had been addressed in line with the providers own complaints policy.

Is the service well-led?

Our findings

We found that regular checks and audits to monitor the safety and effectiveness of all aspects of the service were undertaken both by senior staff, the registered managers and the provider. Records we reviewed confirmed effective action was taken as required when issues were identified. Information about learning and/or changes to practice following incidents was cascaded to staff in a timely manner and reporting of incidents of serious injury to external bodies were appropriately actioned. The provider visited the service regularly and undertook additional monitoring checks. Regular checks of the environment were conducted with people's ongoing safety in mind, including observations in relation to how staff supported people. However, we found they had failed to effectively identify the issues we found during the inspection; for example, the lack of comprehensive guidance available for medicines received in food or via a tube, expiry dates of some analgesic preparations and the application of Deprivation of Liberties Safeguards. This meant that the provider's quality assurance processes were not robust in some areas of care provision.

The provider demonstrated they promoted an open and positive culture which focused on people. People's feedback about their experience of the service was positive. Their comments included, "I do like it here, it's excellent" and "Since I have been here I have had marvellous care. I couldn't get this if I was at home". One person was leaving to return home and we saw all the staff from the unit came to say goodbye and gave the person a hug. The person said to us, "It's the best place I have ever been". Relatives were keen to tell us about how good the home was, they told us, "I have been surprised at how amazing this place is" and "[Persons name] was always sleeping where they were before because he was bored but he smiles and laughs now; I can tell he is happier here. I am really happy with the home, I can't fault it". Another relative described their experience on the day their family member moved into the home, saying, "[Unit manager's name] greeted us at the door with big smiles and reassured us all that everything was going to be okay". We reviewed the previous two months compliments received these included testimonies from people and relatives such as, 'You are all wonderful and we are eternally grateful', 'We could not have wished for any better', 'Thank you for the excellent, professional, dignified care you have given' and 'It has been our privilege to visit and be made so welcome'.

People spoke positively about the management of the home, telling us, "[Unit manager's name] is brilliant she could run the whole place" and "The manager, I think her name is [registered manager's name] she was around the other day, she's approachable". Relatives were equally complimentary about the running of the home, their comments included, "The managers are good here, they are a very nice set of people and they always listen to you" and "[Unit managers name on Manby unit] is out and about she is very involved". There was a registered manager [RM] in post who understood their responsibilities for reporting certain incidents and events to us and to other external agencies that had occurred at the home or affected people who used the service. On the day of our inspection the RM was not available so we were supported by the acting manager [also a unit manager] and the Regional Director; they also understood their responsibilities for reporting certain incidents and events to us.

People were actively encouraged to provide their thoughts and opinions about the service. The provider held regular meetings for people and their relatives to attend where minutes were taken and later displayed

for those unable to attend to refer to. A relative said, "I can't always get to the meetings but I know other relatives will sometimes bring issues up". We saw posters on each unit displaying the dates for monthly meetings for people using the service and also for their relatives. These meetings included an 'open floor' slot as a further opportunity for people to raise any concerns or give feedback. This meant that the provider was keen to actively involve people to express their views about the service provided. One relative told us they had access to information about activities and upcoming events or meetings, saying, "Communication is good, they usually put things on the board outside the unit so you know what's happening". The provider produced a newsletter periodically to further keep people updated and aware of developments within the home.

The provider sent out surveys throughout the year to people, relatives and staff. Of those returned, the comments were overwhelmingly positive. All findings were analysed and displayed in the form of graphs and charts in relation to levels of satisfaction people experienced in a variety of areas, such as food quality and the approach of staff. We saw displayed on each unit the provider had outlined for people 'what we asked, what you said and what we did' from previous surveys. This demonstrated that the provider had taken action to make suggested and necessary improvements following people's feedback.

Staff told us that they were clear about what was expected from them and their direct manager met with them regularly to check on their performance. A staff member told us, "I feel well supported by the managers. I am happy working here". The provider had a management structure that staff were familiar with and understood who they reported directly too. The leadership team consisted of a registered manager who was supported with five unit managers. Other staff members' comments we received about the management team included, "I do feel supported, there is never a time that I can't get hold of someone", "[Unit manager Heronville] gets things done and listens to us if we make suggestions" and "[Unit manager on Palethorpe unit] is a very good manager, you can always talk to her if there's a problem and if something's wrong she sorts it there and then". We saw that unit managers were visible and people clearly knew them well.

Staff meetings held regularly on each individual unit and covered a multitude of key areas, for example results of the staff survey. Staff told us that the registered manager [RM] was also available to them and a 'managers surgery' was held each week, on a drop-in basis for staff to attend to speak to the RM who protected this time in their diary to make sure they were available. Meetings of the heads of each unit and department took place weekly, including housekeeping and maintenance heads; we saw minutes taken from these meetings had agreements in relation to any actions to be taken, by whom and when and these were updated each week. In addition the 'home improvement plan' demonstrated evidence of completion of any actions necessary and updates on progress of other improvements required.

Staff spoken with were aware of their roles and responsibilities in relation to whistleblowing. Following our inspection and before the completion of our report we shared concerns with the provider that were raised with us by a whistle-blower. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about malpractice or wrongdoing; staff should be supported to raise their concerns within the organisation without fear of reprisal. The concerns related to the alleged mistreatment of people using the service. We found that the provider responded to the allegations swiftly, using effective investigation, including unannounced night visits and were able to substantiate some of the allegations. The provider took immediate action to protect people using the service and was transparent in its sharing of information and findings with the involved external agencies. However, an unnecessary delay occurred in contacting the family members of the people who may have been affected by staff actions; but the provider chose to make contact with families when they had some findings to share with them and/or were clearer about how their loved one may have been affected. All of the staff we spoke with told us they felt able to raise concerns and understood what whistleblowing meant. The provider promoted the use of a 'speak up'

telephone line that was available for them to use confidentially if they wanted to raise any concerns. Staff responses in regard to raising concerns and/or whistleblowing included, "I would raise a concern if I needed too. If something wasn't right I would say something and it would be dealt with", "We have a 'speak up' policy here and we have all been told how to whistle blow" and "We have the speak up policy here, although I have never had to use it".

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that ensures providers are open and transparent with people about their care and treatment, as well as with people acting on their behalf. It sets out some specific things providers must do when something goes wrong with someone's care or treatment, including telling them what has happened, giving support, giving truthful information and apologising. The Regional Director who had provided support to us throughout our inspection in the absence of the registered manager was able to tell us their understanding of this regulation and how they reflected this within their practice. We found letters of apology written in relation to omissions and errors that the provider had identified in the service people received; these had been sent out to the person and/or their representatives. We found all the management team supporting us during our inspection were honest, open and transparent in their approach.