

Bupa Care Homes (GL) Limited

Westcombe Park Care Home

Inspection report

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17 August 2018

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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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 16 and 17 August 2018 and was unannounced. Westcombe Park Care Home, is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Westcombe Park Care Home accommodates 51 people in one adapted building. There were 44 people using the service at the time of our inspection.

The service had a registered manager 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.

We inspected Westcombe Park Care Home on 28 and 29 June 2017 and found significant shortfalls. We found multiple breaches of the fundamental standards and regulations. The service was rated requires improvement. Risks to people were not always identified and guidance regarding how to reduce risks was not always followed by staff. We found people's care and treatment was not always appropriate to their needs or preferences. Systems to monitor risk and the safety and welfare of service users were not always effectively operated and feedback from relevant persons about the running of the regulated activity was not always acted on.

We took enforcement action and served a warning notice on the registered provider.

Following this inspection, we inspected the service on 14 November 2017 and found that the service had acted to comply with the warning notice. Regular checks were being conducted to test fire equipment to ensure they were in working order. The home had a fire risk assessment in place and any actions needed to be taken had been actioned. However, we found a continuing breach of legal requirements because people using the service were not being repositioned in accordance with their needs, which placed them at risk of experiencing discomfort and developing pressure sores. We recommended the home review its staffing levels to ensure people's needs were met appropriately. Following that inspection, the provider sent us an action plan showing how they planned to make improvements.

At this inspection, we found that the provider had made improvements. Staff completed risk assessments for every person and there was detailed guidance available regarding how to reduce risks, which staff followed. Although we received a mixed response from people, we found there were enough staff on duty to help support people safely in a timely manner.

Although the provider had made improvements, we found four breaches of the fundamental standards and regulations. Some aspects in people's care plans were incomplete and out of date. Medicines were not always managed safely. Staff asked for people's consent, where they had the capacity to consent to their care. However, staff showed a lack of understanding of the Mental Capacity Act (MCA) and the best interest

decision making process. The provider had systems and processes to assess and monitor the quality of the care people received. However, some aspects of quality assurance process required further improvements.

Staff knew how to keep people safe. The service had clear procedures to support staff to recognise and respond to abuse. The registered manager and staff completed safeguarding training.

The service had a system in place to manage accidents and incidents, and to prevent them happening again. The service carried out comprehensive background checks of staff before they started working.

The provider planned to deal with emergencies and staff were aware of the provider's infection control procedures and they maintained the premises safely.

The provider trained staff to support people and meet their needs. The provider supported staff through regular supervision and appraisal. Staff assessed people's nutritional needs and supported them to maintain a balanced diet. Staff supported people to access the healthcare services they required, and monitored their healthcare appointments. The registered manager and staff liaised with external health and social care professionals to meet people's needs.

People or their relatives, where appropriate, were involved in the assessment, planning and review of their care. Staff considered people's choices, health and social care needs, and their general wellbeing.

Staff supported people in a way which was kind, caring, and respectful. Staff protected people's privacy and dignity.

The provider recognised people's need for stimulation and social interaction. People had end-of-life care plans in place to ensure their preferences at the end of their lives were met. Staff completed daily care records to show what support and care they provided to each person.

The service had a clear policy and procedure about managing complaints. People knew how to complain and told us they would do so if necessary.

The service sought the views of people who used the services, their relatives, and staff to improve the service. Staff felt supported by the registered manager. The service worked effectively with health and social care professionals, and commissioners.

The service had a registered manager in post and they had notified CQC of notifiable events. The last inspection rating of the service was displayed correctly on their website.

The registered manager had knowledge about people living at the home, and made sure they kept staff updated about any changes to people's needs. The registered manager held meetings with staff where staff shared learning and good practice so they understood what was expected of them at all levels.

You can see what action we told the provider to take at the back of the full version of the 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?

Some aspects of the service were not safe.

The provider had not ensured medicines were always being managed safely at the home.

People and their relatives told us they felt safe and that staff and the registered manager treated them well.

The service had a policy and procedure for safeguarding adults from abuse, which the manager and staff understood.

The service had enough staff to support people and carried out satisfactory background checks on them before they started work.

Staff completed risk assessments for every person who used the service with guidance for staff to reduce risks. The service had a system to manage accidents and incidents to reduce reoccurrence.

Staff were aware of the provider's infection control procedures and they maintained the premises safely. The service had arrangements to deal with emergencies.

Requires Improvement 

Is the service effective?

Some aspects of the service were not effective.

Staff asked for people's consent, where they had the capacity to consent to their care. However, we found staff showed a lack of understanding of the Mental Capacity Act (MCA) and the best interest decision making process.

People and their relatives commented positively about staff and told us they were satisfied with the way they looked after them.

The provider supported staff through induction, training, supervision and appraisal, in line with their policy.

Staff assessed people's nutritional needs and supported them to have a balanced diet.

Requires Improvement 

Staff supported people to access the healthcare services they needed. The registered manager and staff liaised with external health and social care professionals to meet people's needs.

The service was adapted to meet people's needs.

Is the service caring?

Good ●

The service was caring.

People and their relatives told us staff were kind and treated them with respect.

People and their relatives were involved in making decisions about their care and support.

Staff respected people's choices, preferences, privacy, dignity, and showed an understanding of equality and diversity.

Is the service responsive?

Requires Improvement ●

Some aspects of the service were not responsive.

Staff assessed people's needs and completed care plans for every person, but some aspects in the care plans were incomplete and out of date.

Staff recognised people's need for stimulation and social interaction.

People had end-of-life care plans in place to ensure their preferences at the end of their lives were met.

People knew how to complain and would do so if necessary. The service had a clear policy and procedure for managing complaints.

Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well-led.

The service had a system and process to assess and monitor the quality of the care people received. However, some aspects of the provider's quality assurance process required further improvements.

People who used the service and their relatives commented positively about the registered manager and staff.

The service had a positive culture, where people and staff felt the service cared about their opinions and acted on their feedback to make improvements.

The registered manager held regular staff meetings, where staff shared learning and good practice so they understood what was expected of them at all levels.

The service worked in partnership with health and social care professionals and commissioners.

Westcombe Park 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 inspection took place on 16 and 17 August 2018 and was unannounced. A specialist nurse advisor, pharmacy inspector, one inspector and an expert by experience inspected on 16 August 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector and an expert by experience returned on 17 August 2018 to complete the inspection.

Before the inspection we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the commissioners and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During the inspection we spoke with 17 people and two relatives, six members of staff, the deputy manager, the registered manager, the regional support manager and the regional director. We observed meal time, interactions between staff, people and their relatives. We looked at nine people's care records, 13 people's medicine records and eight staff records. We also looked at records related to the management of the service such as the accidents and incidents reports, Deprivation of Liberty Safeguards (DoLS) authorisations, health and safety records, and the provider's policies and procedures.

Is the service safe?

Our findings

People and their relatives told us they felt safe and that staff and the registered manager treated them well. One person told us, "Yes, it [the home] just feels to be a safe place." Another person said, "I have never had occasion to feel unsafe." A third person commented, "Yes I do. Because they are around all the time, night and day." One relative told us, "Yeah, I never had any issues on that score."

However, we found medicines were not always being managed safely at the home. Some people at the home were prescribed medicines that can be risky to people and staff handling them. Staff members were not aware of the risks of handling such medicines. The medicine required disposal in a specific waste bin, which was not available at the service. We discussed this issue with the provider and they arranged for a specific waste bin to be provided, which was in place on the second day of the inspection. They also contacted the service's pharmacy for a list of all medicines which can be risky to be people and staff when being handled and told us they would educate staff on how to handle them safely.

We looked at records for people who recently had come to live at the home. We found that staff always did not have an up to date written record of medicines prescribed to them. One person had come to the service with a tin of thickener that was prescribed to them. This was entered on their MAR chart but there was no other record regarding if the person required use of the thickener or not. The provider had contacted a dietician and arranged for them to visit the service, and this visit occurred on the second day of the inspection. However, there was a two-week period before the dietician visited the service and there was a risk the person may not have received this thickener as required.

The home had a medicine management policy in place and staff had received medicines management training. However, some staff members handling medicines had not been competency assessed to ensure they handled medicines safely.

Medicines were stored securely. Staff checked and recorded room and refrigerator temperatures daily. However, for one unit the temperature had been recorded above 8°C throughout July and August 2018. The provider told us this was a recording error, however, staff had not taken any action regarding the high fridge temperature, even though this could have impacted on the effectiveness of medicines. A fridge service engineer arranged by the provider confirmed that the fridge was working correctly and staff had made a recording error. The correct recording of fridge temperature was discussed in staff group supervision meeting.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff giving medicines to people in the morning. Staff gained permission, were polite and caring. They signed for each medicine on people's Medicine Administration Record (MAR) after giving them. Staff supported people to ensure they took medicines safely and had an adequate supply. We looked at MARs and care plans for 13 people. Some people were prescribed high-risk medicines such as

anticoagulants. Anticoagulants are medicines that help prevent blood clots. Care plans for people on such medicines had guidance for staff to identify likely side effects. This meant staff were able to identify the likely side effects and how to manage them. Staff members had recorded allergy status, photograph and room numbers for people to help give medicines safely. Some people took their medicines, such as inhalers, themselves and stored them in their own rooms. There was a system in place to report and investigate medicine errors and incidents. The home had a process to receive medicine alerts and took appropriate action where needed.

At the last inspection on 28 and 29 June 2017 we found risks to people were not always identified and guidance regarding how to reduce risks was not always followed by staff. We took enforcement action and served a warning notice on the registered provider. We undertook a follow-up inspection on 14 November 2017 and found that the service had acted to comply with the warning notice. However, we found a continuing breach of legal requirements because people using the service were not being repositioned when needed, which placed them at risk of experiencing discomfort and developing pressure sores. Following that inspection, the provider sent us an action plan showing how they planned to make improvements. At this inspection, we found that the provider had made improvements.

Staff completed risk assessments for each person and they had detailed guidance for staff to reduce risks. These included pressure areas, nutrition, falls, moving and handling, hydration, fire, choking, and use of bedrails. Although there was detailed guidance in place for staff to reduce risks we found some areas of risk management that required improvement. For example, a person's care records showed that they were steadily losing a small amount of weight but they were not on a food and fluid chart. They had been assessed by speech and language therapist (SaLT) and dietician and their advice stated that food and fluid should be monitored. Further they should be given drinks in a beaker with small holes to avoid the risk of aspiration. During the inspection we saw they are being given a drink from an ordinary glass. We asked the staff member but they did not know about this special beaker and then they appeared to be unable to find it. However, this person was being assisted to eat slowly and carefully and we saw no signs of coughing or choking and the person appeared to enjoy their lunch. This was brought to the attention of the registered manager, who told us they would check if the person still required the use of the beaker..

Another person who was on a PEG [a specialist feeding tube directly into the stomach. The aim of a PEG is to feed those who cannot swallow], feed had a good risk management plan including care of the site. However, the advice from the dietician was to ensure that they were sitting at 40 degrees but in the risk management plan it said 30 degrees. Best practice guidelines state that a 30 degree minimum incline is safe, but could lead to an increased risk of aspiration. . We brought this to the attention of the registered manager, who responded to this immediately by changing the risk management plan, to correspond with the advice, all staff were informed and agreed that they had always positioned the person at 40 degrees although the plan said 30 degrees.

At the last inspection on 14 November 2017, we recommended the home review its staffing levels to ensure people's needs were met appropriately. At this inspection, although we received a mixed response from people we found there were enough staff on duty to help support people safely and in a timely manner. One person told us, "There were very short staffed about 2 months ago." Another person said, "Oh yes, I get treated well, they [staff] can't always stay in here as they are very busy." A third person commented, "Sometimes yes and sometime no." A fourth person said, "I think these places could do with a bit more." One relative told us, "I don't think there ever is enough staff. Organisations like this will be bothered by people wanting something at the same time."

The provider carried out a dependency assessment to identify staffing levels required to meet the needs of

people using the service. The dependency assessment was kept under regular review to determine if the service needed to change staffing levels to meet people's needs. The registered manager told us that in March 2018, 168 additional nursing hours were increased, and that they would continue to keep staffing levels under review to ensure people's needs were met in a timely manner. The staff rota showed that staffing levels were consistently maintained, to meet the assessed needs of the people. If they needed extra support to help people, the registered manager arranged additional staff to cover. The deputy manager told us staff were willing to come in to cover staffing gaps when there was sickness or other staff absences as they wanted to support their colleagues and ensure people received appropriate care.

Staff responded to people's requests for support in a reasonable time. The service had a call bell system for people to use when they required support and we saw staff responded to requests in a timely manner. One person told us, "Oh yes, I always get a response." A third person commented, "I always use it. They do come, it can be longer sometimes, but they always do what you ask them." We tried using a call bell during the inspection in three bedrooms and found staff had responded promptly. On the second day of our inspection, we found five bedrooms call bells were faulty. This was brought to the attention of the maintenance staff and they told us that care staff mentioned to them about two bedrooms faulty bells. However, all five bedrooms' call bells were attended to straight away during the inspection.

The service had a policy and procedure for safeguarding adults from abuse. The registered manager and staff understood what abuse was, the types of abuse, and the signs to look for. Staff knew what to do if they suspected abuse. This included reporting their concerns to the registered manager, the local authority safeguarding team, and the Care Quality Commission (CQC) where necessary. Staff we spoke with told us they completed safeguarding training and this was confirmed by the provider's training records. Staff were also aware of the provider's whistle-blowing procedure and they said they would use it if they needed to.

One member of staff said, "If you see somebody abusing or being neglected, we tell the manager. But nothing has happened to report." The service worked in cooperation with the local authority, in relation to safeguarding investigations. The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The registered manager implemented performance improvement plans for staff to make sure they used incidents as an opportunity for learning. For example, improved communication with external healthcare professionals.

The service had a system to manage accidents and incidents to reduce them happening again. Staff completed accident and incident records. These included actions staff took to respond and minimise future risks, and who they notified, such as a relative or healthcare professional. The registered manager saw each incident record and monitored them. Records we looked at showed examples of changes made after incidents occurred. For example, when a person was found that they had lost weight they were referred to a dietician and a food chart was introduced. In another example, one person was referred to their GP to have their medicines reviewed in relation to a specific medicine [liquid nebulizer] delivered via their PEG, any changes were monitored by staff and no concerns were found. The service had a process for analysing accidents and incidents and identifying if there were any trends, and records showed that this had been discussed with staff during staff meeting to reduce them happening again.

The provider carried out comprehensive background checks of staff before they started work. These included checks on their qualifications and experience, as well as reviews of their employment histories, references, criminal records check and proof of identification. We also saw checks had been made on the registration of qualified nurses with their professional bodies to ensure their suitability.

Staff kept the premises clean and safe. They were aware of the provider's infection control procedures.

Bedrooms and communal areas were kept clean and tidy. We observed staff using personal protective equipment such as gloves, and aprons to prevent the spread of infection. Staff and external agencies, where necessary, carried out safety checks for environmental and equipment hazards such as hoists, and safety of gas appliances.

The service had arrangements to deal with emergencies. Records confirmed that the service carried out regular fire drills. People had personal emergency evacuation plans (PEEPs) in place which gave guidance for staff and the emergency services on the support they would require evacuating from the service. Staff received first aid and fire awareness training so that they could support people safely in an emergency.

Is the service effective?

Our findings

People told us they were satisfied with the way staff looked after them, and that staff were knowledgeable about their roles. One person told us, "Yes, they [staff] always ask me to tell them if I have any issues." Another person said, "It is better now as they have got used to me." A third person commented, "Yes, they do. The staff and I are getting better and better together as we are laughing a lot now."

The Mental Capacity Act 2005 (MCA) provides 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was aware of DoLS and worked with the local authority to ensure the appropriate assessments were undertaken. There were no conditions on people's DoLS and they were supported in the least restrictive manner.

Staff asked for people's consent, where they had the capacity to consent to their care. One person told us, "Oh yes, they [staff] have to ask you, if they want to come in to do my feet, they ask if it is alright." Another person said, "They [staff] do ask when it is time for a shower or bath." Records were clear on people's choices and preferences about their care provision. Staff we spoke with understood the importance of gaining people's consent before they supported them. For example, before giving personal care, transferring from bed or when changing their clothes.

However, we found staff showed a lack of understanding of the Mental Capacity Act (MCA) and the best interest decision making process. For example, there was a lack of information regarding who to contact for one person who was under the palliative care team, in their final days. Staff stated that the next of kin would make all future decisions, although the next of kin did not have a lasting power of attorney (LPA) and there was no mention of decisions being made in the person's best interests. Best interest decisions were not always decision specific. In one person's completed best interests' assessment form, under the decision requiring assessment, it stated, "Has been diagnosed of Alzheimer's unable to communicate meaningfully, mood varies." For another person's best interest assessment for mental health and well-being, nothing was recorded under the decision made, just that the person lacked capacity, under the review on the reverse of the form, it stated that they think, "that none of the medication works" but it did not discuss whether there had been a medication review to discuss with the person, or whether they could articulate why their medicines did not work. For a third person a decision around mental health and well-being only specified that it was necessary to put the person's best interests first and treat them with respect and dignity. This showed a lack of understanding of the MCA in that capacity applies to a specific decision, a diagnosis does not mean a person lacks capacity and that they should be supported to be involved in decisions about

themselves even if lacking capacity to make that decision and that if they lack capacity they cannot give consent and care should be given in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider trained staff to support people and meet their needs. Staff told us they completed comprehensive induction training in line with the Care Certificate Framework; the recognised qualification set for the induction of new social care workers, and a brief period of shadowing an experienced staff, when they started work. The registered manager told us all staff completed mandatory training identified by the provider. The mandatory training covered areas such as allergen awareness, basic life support, food safety, health and safety, infection control, moving and handling and MCA and DoLS. Staff told us the training programmes enabled them to deliver the care and support people needed. The service provided refresher training to staff as and when they needed.

Records showed the provider supported staff through regular supervision and appraisal. Supervision included discussions about staff members' wellbeing and sickness absence, their roles and responsibilities, and their training and development plans. Staff told us they felt supported and could approach their line manager, and the registered manager, at any time for support. One member of staff told us, "Supervision is useful; you learn different things."

Staff carried out a pre-admission assessment of each person to determine the level of support they required, which involved feedback from health and social care professionals, and relatives, where appropriate. This information was used as the basis for developing personalised care plans to meet people's individual needs. The assessment looked at people's medical conditions, physical and mental health; mobility, nutrition and social activities.

Staff assessed people's nutritional needs and supported them to have a balanced diet. People and their relatives told us they had enough to eat and drink. One person told us, "Yes, it is very good actually. I always get two choices." Another person said, "Oh yeah. The other night I did not want the soup and I asked for Scampi and they made me Scampi." Staff recorded people's dietary needs in their care plan and shared this information with kitchen staff to ensure people received the right kind of diet in line with their preferences and needs. For example, we saw information available to kitchen staff on which people needed soft or fortified diets, and special diets. We saw there were alternatives available if people did not like what was offered on the day.

The service protected people from the risk of malnutrition and dehydration. Staff completed nutritional assessments for each person and monitored their weights as required. We saw action had been taken where risks associated with nutrition had been identified. For example, where people were at risk of malnutrition, records showed that staff sought advice from a dietician and completed food and fluid charts to monitor people's intake. We saw during the inspection that staff ensured people were kept hydrated, juices and snacks were available and offered.

People received appropriate support to eat and drink. Interactions between people and staff during a lunchtime meal were positive and the atmosphere was relaxed and not rushed. We observed staff providing support to people who needed help to eat and drink. They had meaningful conversation with people, and helped those who took their time and encouraged them to finish their meal.

Staff supported people to access healthcare services. One person told us, "Oh yeah, they [staff] send for an ambulance to go to the specialist clinic. They are very good at that." Another person said, "Yes, if I need one. The GP comes once a week or fortnight, where you are on a list to see." A third person commented, "I tell the nurse, they arrange it."

The service worked with healthcare professionals including a GP surgery, tissue viability nurse, Speech and Language Therapists (SaLT) and dieticians. A GP visited the home every week to review people's health needs and as and when necessary. We saw the contact details of external healthcare professionals, specialist departments in the hospital, and people's GP were in every care record. Staff completed health action plans for everyone who used the service and monitored their healthcare appointments. The staff attended healthcare appointments with people to support them where needed.

The service met people's needs by the suitable adaptation and design of the premises. There were door guards on all the bedrooms which automatically released in the event of fire. People's bedrooms were personalised and were individual to each person. Some people had bought personalised items from home which had been used to make their rooms familiar and comfortable. We observed people moving freely about the home. Access to the building was controlled to help ensure people's safety.

Is the service caring?

Our findings

People and their relatives told us that staff were kind and treated them with respect. People's comments included "Oh yes" "Definitely" "Very caring." One relative said, "Yeah, on the whole, no deliberate lack of care."

People and their relatives told us staff treated them with dignity, and that their privacy was respected. One person told us, "From what I have seen no problems so far." One relative said, "Yeah, my [loved one] likes the door open so they can see what's going on, but the door is closed for privacy." We saw staff knocked on people's bedrooms before entering people's rooms and speaking to with them politely, and they kept people's information confidential. However, one person who was articulate told us that they were annoyed that staff would talk about their health condition in the dining room as if they were not there. This was brought to the attention of the registered manager, who assured us that they would discuss with staff and deal with this immediately.

We observed that staff communicated with people in a caring and respectful manner throughout the time of our inspection. Staff pro-actively engaged with them, using touch as a form of reassurance, for example by holding people's hands which was positively received.

Staff involved people or their relatives in the assessment, planning and review of their care. One person told us, "Yes, a staff [name] came to our home to discuss." Another person said, "My daughter is involved in my care plan." One relative commented, "In the residents and friends' meetings, my [loved one] being very with it and me bring up things with whoever and usually get our way."

Staff respected people's choices and preferences. For example, staff respected people's decision around where people preferred to spend time, such as in their own room, the lounge or to walk about in the home. Staff told us that they ensured people's choices were respected, such as about clothes, food and drinks, and if they would like to stay in bed or come into the lounge. Staff were aware to use people's preferred name, as recorded in their care plan.

We noticed people's bedroom doors were closed when staff delivered personal care. People were well presented and we saw examples of staff helping them to adjust clothing to maintain their dignity. Records showed staff received training in maintaining people's privacy and dignity.

People were supported to maintain their independence. Staff prompted people where necessary to wash, dress and undress, eat and drink, and brush their teeth. For example, staff told us some people can wash their face and their other parts they washed and encouraged them to choose their clothes.

Is the service responsive?

Our findings

At the last inspection on 28 and 29 June 2017 we found people's care and treatment was not always appropriate to their needs or preferences. An action plan was received to show what actions would be taken to address this.

At this inspection, we found care plans were in place for people. These included food and nutrition, personal care, elimination, sleep, skin care, pressure area care, oral care, wound care, moving around, falls prevention, allergies, communication, and contact details of health and social care professionals. They also included dependency assessments which identified the level of support people needed in areas including identifying the things they could manage to do by themselves. There was some good information to assist staff with providing appropriate care. For example, one person's care plan had person-centred detail included on communication, it appropriately mentioned to make eye contact for someone who required assistance to communicate.

Although action had been taken to address the needs and preferences in people's care plans. Some aspects of people's care plans were incomplete and out of date. For example, one person's care plan stated that they could eat independently using a plate with a guard and a spoon but they were being assisted and we were told by staff that they needed assistance as they no longer ate independently. Some people could display behaviour that could be challenging. One person was described as being, 'verbally aggressive', staff stated in the mental health and wellbeing section of the person's care plan that they had mood swings and that staff should look for the reasons for verbal aggression and assist them to calm down. But staff had failed to specify what the triggers were or what strategies could be used to calm them down.

In a third person's care plan, staff stated that their oxygen, should be monitored, but their oxygen therapy had been discontinued, information regarding this was detailed elsewhere in the person's care notes but their care plan had not been updated. A fourth person, who was an insulin dependent diabetic did not have a mention of their diabetic diet in their eating and drinking care plan.

For a fifth person, there was a geriatric depression scale completed (GDS), which is a self-report measure of depression in older adults. But this person was unable to answer the questions. When asked, a staff member told us they had used what they knew about the person to complete the scale. The score suggested the person was moderately depressed. so, we asked the staff member what action they had taken. We were told that as the person could not answer the questions they could not be certain they were depressed so no action had been taken. The person's food and fluid chart had also been discontinued but the care plan still suggested that this should be done. The person's weight was low, so it was unclear why this had not been continued.

A sixth person's care plan stated that they needed the help of two staff to reposition, but elsewhere in the care plan, it stated that they turned themselves with minimum assistance. We spoke with staff and the person was positioned with the assistance of two staff as they needed to be on their side due to a sacral sore but could and would move themselves on to their back. The care provided was appropriate, but it would

have been difficult for staff who did not know the person to provide the correct care by reading the care plan.

One person who could display behaviour that challenges was seen by the old age psychiatrist, who had prescribed Lorazepam PRN (as required) medicine to be given 30 minutes prior to personal care. A nurse told us they tried calming the person down by reassuring them before giving the medicine if the person was agitated. However, this was not specified in the person's care plan, where it only stated that it should be given if they were agitated. Staff had also asked the person's GP to refer them to the community psychiatric nurse (CPN) on 6 May 2018. However, this inspection was more than 3 months later and there had been no visit and no evidence that there had been any attempt to follow up on this.

Where people were on as and when pain relief there was no evidence of regular use of pain charts. (A pain scale measures a person's pain intensity and other symptoms, and are based on self-report, and observations.) Pain assessment is intended to improve the quality of pain management by systematically identifying people with pain). We saw some numeric pain assessment charts but they had not been completed. Some people with dementia had not had their pain assessed at all, staff told us they did not have any pain but as they were unable to communicate verbally so it would have been useful to monitor pain periodically using an appropriate tool to show this had been considered. An example pain tool was sent to us completed on the day of the inspection. This showed a numerical score of five which suggested moderate pain from the chart but this was then recorded as mild. In the space for recording two things that make that make pain better there is no non-pharmaceutical methods suggested.

The above evidence demonstrates a continuing breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From April 2016 all organisations that provide NHS care or adult social care are legally required to meet the requirements of the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively. The provider identified and met the communication needs of people. For example, people's care plans included details about their communication needs, disability, preferred faith and culture, and guidance for staff to provide care and support that met people's need. The registered manager and staff told us that the service was non-discriminatory and that staff would always seek to support people with any needs they had with regards to their disability, race, religion, sexual orientation or gender.

Staff showed an understanding of equality and diversity. Staff told us that everybody was treated equally, getting the same opportunity of care and that they ensured people's likes were always respected. Staff we spoke with confirmed that people were supported with their cultural and spiritual needs where requested. For example, the provider arranged for people to attend a Church service, to meet their spiritual needs and food that met people's cultural needs.

Staff completed daily care records to show what support and care they provided to each person. They also completed a diary which listed the specific tasks for the day such as who required a weight check, fluid and food intake monitoring, repositioning of people in the bed and skin care management. The service used a communication log to record key events such as changes to health and healthcare appointments for people. Relatives told us there were no restrictions on visitor times and that all were made welcome. We saw staff addressed visitors in a friendly manner, and they were made to feel welcome and comfortable

Staff recognised people's need for stimulation and supported people to follow their interests, and take part

in activities. The service employed an activities coordinator who arranged activities daily. These included bingo, music, arts and crafts, and chair exercises. We observed people reading newspapers, enjoying arts and crafts, and music activities. People responded positively to these activities, for example, we observed people engaged in a musical activity, singing along whilst smiling and laughing. However, there was less opportunity for people who remained in their beds to take part in activities. A new activities co-ordinator had recently been employed to improve this provision.

People received appropriate end-of-life support. Records showed people's end-of-life preferences had been discussed with them, and care plans had been developed to ensure their preferences in this area were met. Staff were aware about the need to continue caring for the family even after the person's death. They also talked about the importance of a quiet and peaceful environment for people and their loved ones at the end of life. The resident experience manager told us that they had been able to help relatives with some of the practical issues after the death of the loved ones, this was especially important when relatives lived abroad. Staff shared an experience of a person where they had been able to trace a family of person, who lived outside the United Kingdom, who were very grateful to be found as this person would have otherwise received a council burial which would not have taken in to account their religion and culture. We saw a booklet from a funeral service where there was a thank you for the staff from the home. The service worked with staff from the local hospice where appropriate, to ensure people's end-of-life needs were met. Staff had also completed end-of-life care training. People had Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms in place where this decision had been discussed with them and their relatives, where appropriate.

People and their relatives told us they knew how to complain and would do so if necessary. One person told us, "I would ask one of the girls to bring me someone. I am very happy." Another person said, "The manager and there is also a nurse, I can talk to." A third person commented, "Yes, I would know. They sort it out and I am happy." One relative said they knew about how to make a complaint and that they are not worried about it. The provider had a clear policy and procedure about managing complaints. We saw information was displayed in the communal areas about how to make a complaint and what action the service would take to address a complaint. The service had maintained a complaints log, which showed when concerns had been raised senior staff had investigated and responded in a timely manner and where necessary staff held meetings with the complainant to resolve the concerns. These were about general care issues and staff attitude. The registered manager told us that there had been no reoccurrence of these issues following their timely resolution. Records we saw confirmed this view.

Is the service well-led?

Our findings

People and their relatives commented positively about staff and the registered manager. One person told us, "I would say, I have been here seven years and reasonably well treated." Another person said, "I think it is very good and I am pleased with them [manager and staff]." One relative told us, "The manager seems to be good, takes an interest in my [loved one], and I talked to him about little improvements and he has said he will try his best."

At the last inspection on 14 November 2017 we found the quality assurance and monitoring process required improvement. The registered manager assured us that action would be taken promptly to address these areas.

At this inspection, we found the service had systems and processes in place to assess and monitor the quality of the care people received. This included checks and audits covering areas such as call bells, health and safety checks, home environment and maintenance, medicines, care plans, staff training and supervision, food and mealtime, and infection control. As a result of these checks and audits the provider developed a home improvement plan and monitored their progress. For example, a new activity coordinator was recruited to improve activities for people who remained in bed. Staff internal communications had improved. Medicines delivery processes with the local pharmacy was improved and the premises had been redecorated where required. A new deputy manager was appointed to support the clinical and management functions.

However, we found the checks and audits had not picked up the concerns we had identified. Therefore, some aspects of quality assurance process required further improvements. For example, People's best interests' assessments were not clear to show what that actual decision was. Where people were on as and when pain relief, there was no evidence of regular use of pain charts. Staff had not followed up with the GP or the community psychiatric nurse (CPN) when their help was needed for a person. Some aspects in people's care plans were incomplete and out of date. Staff did not take action when the temperatures of a medicines fridge were recorded as being too high. There was no safe disposal provided for medicines which could cause harm to people and staff when being handled.

The above evidence demonstrates a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post. Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC then check that appropriate action has been taken. The registered manager had notified CQC of important events as required. . The last inspection rating of the service was displayed correctly on their website.

The registered manager had knowledge about people living at the home, and made sure they kept staff updated about any changes to people's needs. We saw the registered manager interacted with staff in a positive and supportive manner. Staff described the leadership at the service positively. One member of staff

told us, "The manager is understanding and accommodating."

The registered manager held meetings with staff where staff shared learning and good practice so they understood what was expected of them at all levels. Staff told us that there were daily meetings for nurses and senior carers with management to ensure issues could be discussed and problems addressed in a timely manner, there was also a weekly carers' meeting. The daily meetings also took place at the weekend although the management were not present. Records of staff meetings showed that areas discussed had included details of any changes in people's needs, guidance to staff about the day to day management of the service, discussions about co-ordinating with health and social care professionals. Staff also discussed the changes to people's needs during the daily shift handover meeting to ensure continuity of care.

The service had a positive culture, where people and their relatives felt the provider cared about their opinions and included them in decisions. The provider arranged quarterly residents and relatives meeting and sought people's views using satisfaction surveys. As a result of this feedback, the provider had made improvements for example, staffing levels and meal time experience was improved, and an activity coordinator was employed. We observed that people, relatives and staff were comfortable approaching the registered manager and their conversations were friendly and open.

Care records we saw showed that the service worked with health and social care professionals, commissioners, hospice, speech and language therapist, and the hospital. One social care professional told us, that the standards and quality of care delivered by the service to people had improved and that they were happy with the management and staff at the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Some aspects in the care plans were incomplete and out of date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Staff showed a lack of understanding of the Mental Capacity Act (MCA) and the best interest decision making process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider and the manager had not ensured medicines were always being managed safely at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Some aspects of the provider's quality assurance process required further improvements.