Bramble Lodge Care Home Limited

Eastgate Manor

Inspection report

Mickley Square
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Northumberland
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Eastgate Manor is situated Mickley, Northumberland, close to the town of Prudhoe. The service provides accommodation and personal care including nursing care, for up to 44 people some of whom are living with dementia. On the day of the inspection there were 28 people living at the service. Care was provided over three floors. Personal care was provided on the lower ground "residential" unit, the middle floor provided nursing care and the top floor provided care to people living with dementia.

The service was last inspected on 06, 09, 12, 25, 26 November 2015 where we found seven breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, good governance, and staffing. There was also one breach of Care Quality Commission (Registration) Regulations 2009 related to notification of incidents. The service was rated inadequate in all five domains and placed in special measures.
The provider sent us an action plan to show us how they would address our concerns. The action plan stated that all actions would be completed by 4 December 2015

At the last inspection in November 2015, we asked the provider to take action to make improvements to dignity and respect, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, governance, staffing and notification of incidents, and this action has been completed.

There was no registered manager in post. A manager had been appointed who was in the process of registering with the Care Quality Commission (CQC). 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.

Health and safety checks on the premises and equipment had been carried out. Risk assessments related to the building and individual risks to people were in place. Regular spot checks and audits had been carried out by managers. However, the provider was unable to locate the most recent legionella risk assessment and an electrical test being carried out on the day of the inspection was overdue.

A safeguarding policy and procedure was in place and staff had received safeguarding training. Staff were knowledgeable about the procedures to follow in the event of concerns. A number of issues were being looked into by the local authority safeguarding team who were working closely with the service.

The premises were clean and well maintained and recently refurbished. Infection control procedures were followed and person protective equipment (gloves and aprons) used to help to prevent the spread of infection were available, but was not always distributed effectively to enable staff to locate them in a timely manner.

Suitable numbers of staff were on duty during the inspection. The service continued to use high numbers of agency staff but arrangements were in place to employ the same staff to provide consistency. A recruitment drive was ongoing, and staff had been deployed to the home from other services to improve the skills mix and leadership while recruitment took place. We have recommended that the skills mix continues to be monitored until more permanent staff are in post.

Safe recruitment procedures were followed. There were a small number of gaps in recruitment records but the overall process was robust. A record of accidents and incidents was maintained and analysed monthly to identify trends or concerns.

Training was provided in key areas and updated regularly. Systems of staff supervision and appraisal were in place and staff told us they felt well supported.

People had access to health care in a timely manner. This had been a concern at the last inspection. Some professionals felt however, that there was now a tendency to over report health concerns for fear of failure to act. This was impacting upon the workload of all involved. Advice from visiting professionals was acted upon however, we found one occasion when a piece of equipment had been recommended and had not been sourced in a timely manner. We found that where a professional had not visited a person as planned, that prompt action had been taken by staff to ensure that the appointment was rearranged for the following day.

People were supported with eating and drinking, and we were told that meals had improved. Food and fluid intake was recorded and weights of people were monitored. A new chef was in post. Appropriate support was given to people during their meal although people living with dementia would benefit from further support to make meal choices.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. it also ensures unlawful restrictions are not placed on people in care homes and hospitals.

The service was operating within the principles of the Mental Capacity Act (2005) and capacity assessments had been carried out. Applications had been made to deprive people of their liberty and best interest's decisions were recorded. These did not always detail who had had been involved in the decision making process.

People, relatives and visiting professionals told us that people appeared well cared for. Kind, caring, and meaningful interactions with people were observed. People experiencing distress were attended to promptly, with the exception of one person who had to wait some time. Some staff appeared to lack initiative to sit and chat with people and spent periods of time sitting in the lounge with the television on while people slept. Some people had hairstyles which appeared unkempt, but people were generally clean and tidy in appearance.

Care plans were in place and had improved since the last inspection. They were up to date and had been regularly reviewed. They were, however, lacking in person-centred information although steps had been taken to address this with the introduction of personal profiles. This information had not been incorporated into care plans as yet.

An activities coordinator was in post, and we saw records of a number of activities that had taken place. We found little evidence that activities were planned around the specific interests or needs of people, and there was a focus on group activities. Records related to how well people had participated in activities, were brief and made evaluation of activities difficult. We have made a recommendation about this.

An interim manager was in post and was in the process of being registered with CQC. There were plans to replace them with another manager who had been appointed following completion of their probationary period. Relatives and staff said they found the turnover of managers unsettling and were hoping for a period of managerial stability.

Quality assurance systems had been improved and there were regular checks audits and spot checks carried out by senior managers.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe care and treatment and person centred care. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Safety checks to the premises and equipment had been carried out. An up to date Legionella risk assessment was not available. An electrical safety test carried out on the day of the inspection was overdue.

Personal protective equipment was available but not distributed to be accessible in a timely manner in all areas of the service.

Safe recruitment procedures had been followed.

Sufficient numbers of staff were on duty on the day of the inspection and recruitment was ongoing to replace staff who had left the service and to reduce the numbers of agency staff employed.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Training and supervision carried out regularly and staff felt well supported.

Access to health care and treatment had improved but the advice of a health professional had not been followed on one occasion.

People were supported with eating and drinking. People living with dementia would benefit from additional support to choose their meals.

The service was operating within the principles of the Mental Capacity Act (2005).

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

We observed that some people had hairstyles that appeared unkempt. People appeared otherwise clean and tidy in

appearance.

We observed kind and caring interactions with people but some staff lacked initiative to chat with people and spent long periods of time on the lounge in silence while people slept.

Language used by staff was not always person centred and referred to people as a task as opposed to a person requiring support.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Care plans were in place and these were up to date and had been regularly reviewed. They were lacking in person centred information about people including personal history, preferences, and wishes.

An activities coordinator was in post but the range of activities available to people was limited and were not planned around individual people's hobbies or interests. Documentation related to the participation in activities was basic.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

A manager had been appointed and was in the process of registering with CQC. They were supported by a deputy manager who was an experienced nurse.

Quality assurance systems had improved and regular checks and audits were carried out by senior managers.

Staff said they felt well supported by the manager but were concerned by the lack of stable management within the service. Relatives and one person told us they were keen to see a permanent and stable management team in post.

Eastgate Manor

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 10 May 2016 and was unannounced. It was carried out by one inspector and an inspection manager.

During the inspection we displayed a poster to inform people that we were inspecting the service and invited them to share their views.

We spoke with six people who lived at the service and four relatives during our inspection. Prior to the inspection we spoke with local authority commissioning team and safeguarding officers. Both teams were aware of the concerns raised at the previous inspection and were working closely with the service.

We spoke with a community matron before the inspection, and a GP and district nurse who visited the service regularly on the day of the inspection.

We spoke with the nominated individual, operations manager, deputy manager (also a registered nurse), and five care workers on the day of our inspection. We also spoke with kitchen and domestic staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of four people who used the service, and four staff recruitment files. We also reviewed safety and maintenance records and records relating to the management of the service.

Prior to the inspection we reviewed all of the information we held about Eastgate Manor including any statutory notifications that the provider had sent us and any complaints we had received. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration)

Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We took this information into account when planning our inspection.

Requires Improvement

Is the service safe?

Our findings

During our inspection we received information of concern about staffing levels, availability of equipment and some aspects of care. We referred this information to Northumberland safeguarding adult's team who were already involved with the service. We took this information into account when carrying out our inspection and reviewed this information as part of our inspection.

At the last inspection we found that people were not protected against risks for example, in relation to safeguarding, equipment for moving and handling of people, safe management of medicines, accidents and incidents monitoring and the environmental safety. At this inspection we found that improvements had been made in relation to the assessment of and mitigation of risks to people. However, we also found that not all of the required safety checks to the premises had been carried out, or could be evidenced during this inspection.

Relatives told us they felt their family members were safe. One relative told us, "I have never had any problems with the care my relative has received. I've never met any staff with a bad attitude or anything like that". Another relative told us, "I was surprised at the findings of the last report. If I had any problems with the care I would never have kept (name of person) here. I've never seen anything at all to concern me".

A number of health and safety checks of the premises and equipment were in place. On arrival to the service we checked the premises and found that cupboards and rooms that needed to be inaccessible to people for safety reasons, were locked. Hand soap and gels had been removed from the corridors in one area of the service due to the potential for it being misused and following a risk assessment. We found however, that denture cleaning tablets were stored in some en suite bathrooms which were accessible. We did not see any risk assessments in relation to this. Daily and weekly checks were carried out including checks of fire alarms, emergency lighting, passenger lift, nurse call system and water temperatures. Equipment used for the moving and positioning of people was in working order. The provider was unable to locate the most recent Legionella risk assessment, and an electrical safety inspection which was taking place on the day of the inspection was three months overdue.

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

Records of accidents and incidents were maintained and analysed monthly by managers to identify any trends of concerns. Copies of these were held in individual people's care records. These included the frequency of falls, for example, and whether appropriate action had been taken following accidents or incidents.
Care records contained risk assessments relating to people's physical health needs including nutrition, skin integrity (to prevent pressure ulcers), and risk of falls. These were up to date and had been regularly reviewed. Personal emergency evacuation plans were displayed on the back of people's bedroom doors. These described the amount of support a person would need in the event of an evacuation. A poster was displayed relating to the positioning of people to prevent pneumonia. We asked staff what the posters

meant and they were able to tell us why this was important.

At the last inspection we found that people who used the service were not protected from the risk of abuse or improper treatment because training had expired for over half of staff and a number of serious safeguarding incidents had occurred, which had not been reported to Northumberland safeguarding adult's team for investigation. We found that this had improved and that appropriate procedures were in place. We checked the training matrix and found that training had been provided to all staff.

A safeguarding policy and procedure, which informed staff how to recognise and report suspected abuse or neglect, was in place. Staff knew what to do in the event of concerns and one staff member told us, "I've done safeguarding training, all the staff have to. I have never seen anything to concern me, but I would report it straight away if I did. This is a very nice home". We spoke with a representative from the local authority safeguarding team who had been visiting the service on a regular basis. They told us that the service remained in overarching safeguarding proceedings which meant that a number of individual people, and the service overall was being monitored by the local authority safeguarding team. They were continuing to work closely with the service and said that reporting of safeguarding concerns had increased but that this was probably due to the heightened awareness of staff who were being extra diligent as a result of the previous inspection findings.

We checked the premises and found them to be clean and well maintained and recently refurbished. We found a small number of pedal bins with broken pedals which we reported to senior managers who said they would replace them. There were no malodours, and we spoke with a member of domestic staff who told us there were suitable numbers of domestic staff on duty to ensure that the service remained clean. Infection control procedures were in place and staff had received relevant training. One member of domestic staff told us, "We get regular training updates about infection control and we lock cleaning products away". We spoke with a visiting health care professional who told us that personal protective equipment such as gloves and aprons were not always readily available. We observed that there were ample supplies of this equipment but it was not distributed throughout the service to ensure it was available in a timely manner when required.

We recommend that best practice is followed in relation to the availability of personal protective equipment.

At the last inspection we found that the provider had failed to ensure that there were sufficient numbers of suitably skilled staff on duty at all times. We found that this had improved since the last inspection and that recruitment was ongoing.

We found that there were suitable numbers of staff on duty during the inspection. A clinical lead had been appointed since the last inspection. A number of posts were vacant and the provider was trying hard to fill gaps in staffing through an ongoing recruitment campaign. A banner was displayed outside the home and during the inspection an interview took place and we saw a potential recruit being shown around the service.
High numbers of agency staff continued to be used although staff, people and relatives told us that they had noticed that the same agency staff were booked on a regular basis to aid consistency. One staff member told us, "We are sometimes short staffed but the gaps are always filled with agency so we have the right numbers of staff on duty". A relative told us, "There are always enough staff on duty. It was a problem before the last inspection as there was only two (in the unit) which wasn't enough, it was dangerous. Now there are three and that seems to be enough". Another relative told us, "The difficult phase seems to have passed and I see much more stability. They [provider] have recruited more staff and there seems to be more regular

staff". Overall this meant that there was greater consistency in the staff deployed and fewer vacancies however we were advised by senior managers that the skills mix and staffing would remain under review until a stable staff team was recruited and use of agency staff has significantly reduced.

We checked the recruitment records of three staff members. We found that appropriate checks had been carried out, including receipt of suitable references and checks by the Disclosure and Barring Service (DBS). The DBS provides information to employers about whether applicants are barred from caring for vulnerable people, enabling them to make safer recruitment decisions. We found that the interview forms were not always fully completed and had not been signed by the relevant manager. The recruitment procedure was thorough despite the small number of gaps in records and we were sent supplementary evidence following the inspection which explained these gaps.

At the last inspection we found that medicines were not managed safely. This had improved at this inspection. We checked the management of medicines and found that there were suitable procedures in place for the ordering, receipt, storage, administration and return or disposal of medicines. Medicines were stored at the correct temperature which is important as the effectiveness of some medicines reduces if stored incorrectly. Room and fridge temperatures were checked twice daily and weekly stock checks were carried out by two staff. We checked the quantity of a controlled drug (controlled drugs are medicines liable to misuse) and found the correct amount in stock. We checked the administration of medicines that needed to be given at specific times, and medicines that should not be missed such as antidepressants or cognitive enhancers (anti dementia drugs). Medicine administration records (MAR) showed that these had been administered correctly. We looked at MARs on the top floor for the previous month. We found one gap in records and saw that very few medicines had been refused by people. Where this had been the case we saw that appropriate action had been taken and that this was recorded. Regular audits of medicines management had been carried out and staff had received training and competency checks to administer medicines safely. We observed medicines being administered and the staff member was wearing a red tabard which advised that they should not be disturbed while administering medicines. We also saw a staff member administering medicines without the tabard. This meant that the provider's procedures for the administration of medicines were not always consistently followed.

We recommend that the provider follows best practice guidance in the safe administration of medicines.

Requires Improvement

Is the service effective?

Our findings

Staff received regular training and we reviewed the training matrix supplied by the provider and found that training was up to date in key areas including health and safety, infection control, safeguarding vulnerable adults, moving and positioning (of people), medicines awareness, and diet and nutrition. Training in dementia awareness and understanding and management of behaviours that challenge, had also been completed by some staff. A high use of agency staff meant that the skills mix in the service was somewhat difficult to determine, however, steps had been taken in an attempt to provide consistency and continuity of care by skilled and experienced staff by moving staff to the home from other services within the organisation.

One visiting healthcare professional told us, "It can be difficult when you are dealing with agency staff as they will often say they don't know, or they haven't been on duty, but they will have had a handover, and I haven't so they should know what is going on". Another healthcare professional told us, "There has been a lot of upheaval with staff and they might say; "I'm only here for the day, or I don't know this patient" but (name of deputy manager) is very good and consistent".

We observed very skilled interventions from one such member of care staff who role modelled best practice and was spoken of highly by relatives and visiting professionals. One relative told us, "I had a review meeting with (name of staff member). It was very professional and very thorough". Another relative told us, "I really hope (name of staff member) doesn't have to move. They have made such a big difference and knows exactly what is going on and how to deal with everything". We were concerned about the impact upon the service of these skilled experienced staff being moved back to their original service and we spoke with senior managers about this. They were conscious of this and were trying to maintain stability for as long as possible.

Supervision and appraisal of staff was carried out regularly and staff told us they felt well supported. One staff member told us, "My line manager is the housekeeper and I have supervision with them around every six weeks. I just need to go to them if I need anything, I get plenty of support". This meant that the support and development needs of staff were met.

Access to health care and treatment had improved but the advice of a health professional had not been followed on one occasion where a piece of equipment had been recommended but not obtained in a timely manner. The professional involved told us however, that they felt apart from on this occasion, that their advice was followed and people appeared well cared for.

We spoke with a GP who visited the service regularly and told us, "There are no delays in seeking medical treatment and at no point have I thought that people weren't being well cared for". There was a perception amongst professionals that staff were at times over reporting due to fear of missing information.

One person was due to be visited by staff from a clinic to monitor medicines to treat their medical condition. They had not turned up and staff noticed this and immediately contacted them. The appointment was

booked for the following day and staff sought written confirmation that the person's medicine dosage could remain unchanged until the visit. This demonstrated an improvement in the monitoring of health needs and timely access to services which had been a concern at the last inspection.

At the last inspection we found that the provider did not have appropriate arrangements in place for people to receive suitable nutrition and hydration. During this inspection we found that people were supported with eating and drinking and a new chef had been appointed. A relative told us, "The food has definitely improved, there are new four week menus; someone has worked very hard on them. My relative didn't eat and was on a fortified diet and they make sure her drink is thickened. They didn't always do that before, they were supposed to, but it wasn't always implemented but it is now. They have put weight on". Another relative told us, "There seems to be more effort into menus. We see more evidence of fresh fruit and more water. People are offered a piece of cake or fruit". We visited the kitchen and spoke with the chef who was aware of the special dietary needs and preferences of people. A number of people were receiving fortified diets to help them to gain weight and we saw that this was monitored. The Malnutrition Universal Screening Tool (MUST) was in use. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. The records we checked had been regularly reviewed and updated.

We joined people at lunch time on the top floor and saw that people received appropriate support to eat their meals. Clothing protectors were offered with an explanation about why they might be useful but people were given the choice of whether to wear them. A choice of tea, coffee or juice was available with the meal. Staff offered people a choice of meal and told us that although meals were selected in advance, they were aware that people sometimes changed their mind so alternative choices were always available and they did not stick rigidly to menu choices. One person declined both choices available and requested fish and chips instead. Staff contacted the kitchen and the chef brought their fish and chips a short time later. A staff member described the meals available to one person, who had difficulty in understanding what the choices were. They were not offered visual clues such as being shown the two choices or picture menus.

Another person was offered sweet and sour chicken or fish and didn't know which to choose and said to the staff member, "You decide". The staff member said, "Why don't you try a little bit of the chicken then, and if you don't like it you could change it for some fish". The person replied, "What a good idea!" We saw that they thoroughly enjoyed the chicken which they finished.

We recommend that best practice is followed in relation to supporting people living with dementia to make choices at mealtimes.

Some people were restless and found it difficult to sit still to eat their meal so a care plan was in place which recommended that finger foods should be readily available to them to eat as they walked around. We saw that these foods were provided and that although people were encouraged to sit at the table with others, staff were aware of their need to move around the unit and supported this.

We checked the completion of food and fluid charts upon arrival to the service and found that these were complete and up to date. We observed that these were completed as soon as practicable following meals. Daily targets for fluid intake had been calculated based upon the body weight of people and these had replaced an arbitrary target of 1,550 millilitres which had previously been set for everyone. This meant that staff aimed to ensure that people's individual hydration needs were met.

At the last inspection we found that the provider was not adhering to their legal responsibilities under the mental capacity act 2005. We found that improvements had been made to the application of the act and

associated record keeping.

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

The service was operating within the principles of the Mental Capacity Act (2005). We checked care plans and found that mental capacity assessments had been carried out in relation to specific decisions such as the decision to reside permanently at Eastgate Manor, Do Not Attempt Cardiopulmonary Resuscitation orders (DNAR) and the use of bed rails. Best interest's decisions were recorded but these did not always evidence who had been involved in decision making, including members of the multidisciplinary team and family members. A number of applications to deprive people of their liberty (DoLS) had been submitted to the local authority for authorisation in line with legal requirements.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found that people were not always treated with respect and their dignity was not promoted. During this inspection we found that this had improved, although there was room for further improvement.

We observed staff speaking kindly with people and treating them with respect throughout our inspection. One person told us, "All I have known is affection, they are like family. They are as cheerful at the end of a 12 hour shift as when they start".

Another person gave us mixed views about the staff including care staff and nurses, stating that most were nice but some weren't as good as others. They told us they had made a complaint about a member of staff and that this had been dealt with.

Some staff lacked initiative to chat with people however, and spent long periods of time in the lounge in silence while people slept. We noted that language used by staff was not always person centred. One person was distressed and crying and we were told that staff could not attend to their needs at that time as they still had "feeds" to do. This was an example of referring to people as a task as opposed to a person requiring support and was considered poor practice. This was not widespread during the inspection and we found most staff warm, courteous and caring.

We observed positive interactions between people and staff. One person was delighted to see a member of staff and said, "I told them I was missing you, you're one in a million". The staff member fondly exchanged compliments with the person. People were offered reassurance for example when a person was being transferred in a hoist. We saw that staff explained what was happening and spoke gently to the person and offered reassurance throughout. They then asked the person where they would like to sit. Another person was fearful and anxious and staff responded promptly to them and provided reassurance that there was nothing to be worried about.

Relatives also told us they thought people were well cared for. One relative told us, "I have never had any issues with the care. My relative is settled and happy. The staff are always very helpful and want to make things as good as they can be for the people who are here". Another relative told us, "The staff are very caring and patient". A GP told us they were happy with the care provided to people who they described as being complex to care for in the community, but had improved significantly since moving into the service.

We observed that some people were unable to express themselves verbally, and that staff responded to them when their appearance changed and they looked upset. A relative told us, "The staff are very good at working out what is likely to be wrong". We saw staff supporting one person who looked upset and was visibly reassured by their presence.

People told us that their views were respected including their religion and that choices were promoted. We asked one person if their religious beliefs were respected and they told us, "Oh very much so". They also told

us they had choices about when to get up and go to bed and said, "I tend to get up at the same time and I just ring the bell. Once I didn't ring the bell and they came to check because I hadn't rung. It's just like a family would do".

We observed that people were generally clean and tidy in appearance but noted that some people had hairstyles that had grown out and appeared unkempt in excess of having missed the hairdresser on one occasion. One person told us they had missed the hairdresser on the previous two occasions which had upset them as they liked to keep their hair short. We passed this issue to the senior staff on duty so they could ensure that the person was given a priority appointment or taken to a local salon, which they said would not be a problem.

We observed that the dignity of people was maintained and we saw staff knocking on people's doors and asking permission to enter throughout the inspection. One person told us, "They knock on the door and they are polite when they talk to you. They say "excuse me" and "how are you?"

No one was accessing any formal advocacy at the time of the inspection but staff told us they knew how to access this service if necessary.

Requires Improvement

Is the service responsive?

Our findings

There was mixed feedback regarding the responsiveness of the service. Some people told us their needs were responded to. One person said, "When I was ill, they were straight there doing my temperature and straight away they got the doctor". One relative told us they did not think their relative's needs were responded to. They told us, "Care plans aren't adhered to. My relative needs (a particular intervention) for their quality of life and comfort and it hasn't been consistently provided". They also told us their relative's preferences with regards to how personal care was delivered was not always accommodated either and this had caused their relative to be very upset. The provider was aware of these concerns.

Care plans were checked and we found that they had improved since the last inspection. Senior managers acknowledged that care plans continued to be developed but we observed that any shortfalls were highlighted and action taken to remedy these. The care plans we checked were up to date and had been regularly reviewed. They included assessments and care plans based upon the activities of daily living including mobility and falls, dietary needs including skin integrity, personal care, communication, and psychological assessments such as the assessment of mood or behaviour.

Care plans were lacking in person centred information and it was difficult to get a sense of the individual person the care plans related to when reading them. Person centred care plans take into account people's personality, behaviour, likes, dislikes and previous experiences. We spoke with a care manager who told us, "There is not a lot of evidence of person centred care planning". Some attempts had been made to address this with the introduction of personal profiles and "This is Me" This is Me is a tool published by the Alzheimer's Society which details personal information about people which might be of use if they were admitted to hospital. They are intended for hospital use and are therefore not sufficiently detailed to constitute life story work. Care plans did not incorporate this information to make them more personalised. Some care plans were lacking in detail. The activities care plan of one person consisted of an instruction that they were "to be informed of all activities". There was no information about the types of activity that might interest them, or assessment of their abilities in order to support the activity planning process.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

An activities coordinator was in post but not on duty on the day of the inspection. We did not observe individual activities during the inspection but an entertainer visited the service in the afternoon and sang to people which they enjoyed. An activities board was displayed on the wall with a number of activities advertised. People and relatives told us they felt that activities were limited. One person told us, "There's posters on the wall about activities but I've come to the conclusion it's all lies because when you ask there is never anything on. There used to be two activities coordinators now there is only one". A relative told us, "My only concern was to do with the lack of activities. There is a lack of mental and physical stimulation. You see some people staring into space with the TV on. There are occasional music afternoons and a minister comes for communion about once a month. I have been told it is being addressed".

Records related to the activities that people had participated in were limited. We viewed some records in the service on the day of the inspection and were sent additional records held by the activities coordinator that we had not seen, immediately following our inspection. These included a slightly broader range of activities, a number of entries related to group activities such as sing along and chair exercises and watching television or films. People had also taken part in group craft activities and had enjoyed sitting together in the sun. Participation was simply indicated with a "Y" or "N", and there was no record of the level of participation or evidence of any individualised activity planning related to the hobbies, interests or past life experiences of people. Activities provided to people living with dementia need to be carefully planned due to the potential to undermine self-confidence or feelings of self-worth of people by either making the activity too simple, or too difficult. Careful monitoring of the response to activities was therefore important and this had not occurred. Consideration also needed to be given to people who spend long periods of time alone in bed for example or who remain too frail to participate in mainstream activities. We acknowledge the improvements that have been made and the impact of reduced numbers of permanent staff upon activity planning and delivery.

We recommend that work continues to further enhance the person centred planning and evaluation of activities to ensure that people's social and intellectual needs are met.

A complaints procedure was in place. People told us they knew how to make a complaint, and a number said they had not needed to. A complaints log was available and contained only one recorded complaint. Further individual complaints had been received and were recorded separately. Evidence was seen of responses to these. A review of complaints was carried out during operations manager monthly visits where they reviewed whether any complaints received had been investigated in a timely manner, had identified learning or action points, and whether these had been shared with staff.

We recommend that all complaints are logged in line with the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found that governance arrangements were not sufficiently robust to protect people from against risks as an effective system for monitoring the service was not in place. We also found that regulations related to the legal requirement to notify CQC of certain incidents had not been met. We found improvements in both of these areas during this inspection although there had remained some delays in sending statutory notifications. We fed this back to the provider for monitoring.

Notifications related to authorisations to deprive people of their liberty had not been sent to CQC upon authorisation by the local authority, but were sent retrospectively following this inspection. We will not be taking any further action with regard to these as we took enforcement action following the last inspection related to non-notification which covers the period concerned. We will continue to monitor the timeliness of submission of notifications in line with legal requirements.

A new manager was appointed in October 2015 and had left the service in March 2016. An interim manager was in post at the time of the inspection, who was in the process of registering with CQC. Another manager had also subsequently been appointed and there were plans for them to register with CQC following a period of induction and probation. The manager was supported by a deputy manager who was also a registered nurse.

Staff and relatives told us that they had found the lack of a manager for a consistent period of time unsettling. One staff member told us, "The new manager is nice but I don't think they're going to stay. I would like a manager to stay longer and not change all the time. I think changing the manager all the time lets the staff down a bit". We spoke with three relatives and a GP who told us they had very little to do with the manager or had not spoken to them at all. Two relatives told us that although they had been shocked by the findings of the previous inspection, they were not surprised that some failings had been attributed to management and systems, as they felt that the lack of a permanent manager had contributed to this and they hoped that this would improve. One relative told us, "I hope they get a new manager. They never stay long and I don't know why; it's a lovely home".

Systems to monitor the quality and safety of the service had improved. Regular "flash meetings" took place and one was in progress as we arrived at the service. A nominated individual, operations manager, deputy manager and heads of department were in attendance. Flash meetings were held daily and issues affecting people who lived in the service, building and premises, and staff were discussed. Topics discussed included, safeguarding, Mental Capacity Act, health and safety, dignity and respect, accidents and incidents, concerns about individual people, hospital appointments and GP visits, activities, maintenance and housekeeping. One visiting professional expressed concerns about these meetings being held in the foyer of the home as they said they had overheard the content of a meeting. We fed this back to the provider.

Spot checks had been carried out by managers to monitor the quality and safety of the service. We saw that a night time visit had been carried out by a manager who checked the security of the building, staffing levels, cupboards that should be locked, and completion of fluid charts. The provider had undertaken a health and

safety audit in February 2016 and quality monitoring reports had been completed in relation to staffing, medicines, the results of audits, infection control and discussions with staff. A dining experience observation tool had been used to assess the quality of the mealtime experience of people, which looked at ambience, accompaniments, and staff support.

A system of clinical governance had been introduced. Clinical governance is a systematic approach to improving the safety and quality of care and includes the management of risks, clinical audit, and training and development.

Record keeping had improved since the last inspection. Systems were in place to monitor the quality of care records and we saw for example that care plan audits had been carried out. These identified some shortfalls in records which were then addressed by staff. We spoke with the operations manager who told us that they had made improvements but were aware that there was still progress to be made and that quality would continue to be monitored.

Regular meetings had taken place with people, relatives and staff. One had taken place in March and ten relatives had been in attendance. Issues discussed at the meeting included management changes, results of surveys regarding the laundry service, activities, meals, staffing, refurbishment of the premises and the overall strategy for improvement. Satisfaction surveys had been provided including in relation to the laundry and menus specifically, and also customer satisfaction in general. One relative told us, "I came to some meetings following the last inspection, and was told what was happening. There was a period of some turmoil but we were kept informed and things have definitely improved".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred meaning that they did not sufficiently take into account people's personality, behaviour, likes, dislikes and previous experiences when planning care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with Legionella bacteria as evidence of a risk assessment could not be provided and the five year electrical safety test was overdue.