Bupa Care Homes (ANS) Limited

Manley Court Care Home

Inspection report

John Williams Close
Off Cold Blow Lane, New Cross
London
SE14 5XA

Tel: 02076354600

Date of inspection visit:
21 July 2017
24 July 2017

Date of publication:
05 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 and 24 July 2017 and was unannounced. At the time of the inspection there were 77 people using the service. Manley Court Care Home provides accommodation with nursing care for up to 85 people. People using the service are younger adults and older people, some people are living with physical health difficulties, and others with dementia.

On 18 and 23 March 2016 we carried out a responsive inspection in relation to information of concern we received. We found a continued breach of the regulations related to staffing levels. We also identified new breaches of regulations in regards to good governance, safeguarding service users from abuse and improper treatment, the need for consent and notifications. The service was rated as Requires Improvement overall. You can read previous inspection reports of the service, by selecting the 'all reports' link for Manley Court Care Home on our website at www.cqc.org.uk.

Currently the Care Quality Commission (CQC) and the Fire Authority continue to be involved in investigations of the concerns we were informed of.

We followed up on the breaches of regulations to see if the registered provider had made improvements to the service. We found that the registered provider had taken some action to meet the regulations. The improvements we found were in relation to safeguarding service users from abuse and improper treatment, need for consent and notifications. However we found continued breaches in good governance and staffing. New breaches in relation to safe care and treatment and meeting nutritional and hydration needs were also found.

The registered provider had employed a new home manager after our last inspection and they had successfully completed their application with the CQC to become the registered manager. A registered manager is a person who has registered with the CQC 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 found that people had risk assessments in place. Staff identified risks to people's health and wellbeing. However we found that the control measures in place to manage people's risks including the risk of harm from fire were not always followed to keep people safe.

Medicines were not managed safely. We found medicine administration record (MAR) charts were not accurate or up to date and medicines were not always stored safely. People were at risk of receiving medicines that were not administered as prescribed.

People who used the service, relatives and members of staff continued to raise concerns about the level of staffing at the service. The dependency tool in place assessed the number of staff required to meet people's needs. We found that at times staffing levels did not always meet the needs of people living at the service.

Records relating to people's ability to consent to care and support were not always accurate or up to date. Staff sought people's consent to care. This was obtained in writing for complex decisions and verbally from people using the service for simple decisions that needed to be made.

The meals provided at the service met people's preferences. Where people required a specialist diet this was provided to help them maintain their health and wellbeing. However, we found that people's nutritional needs were not always effectively met.

Health and social care professionals were involved in people's care and support needs when required. People had access to health and social care services when their needs changed.

Staff understood what action to take to keep people safe from abuse. Staff followed the registered provider's safeguarding procedures to protect people from the risk of harm. People told us that staff listened to their views and opinions. Staff provided care to people that showed that they respected their dignity and privacy.

Staff had received appropriate support from their line manager. Staff had access to training, supervision and annual appraisals to support them in their role. New members of staff had an induction which helped them to familiarise themselves with people using the service and the registered provider's policies and processes.

Care assessments were carried out for people using the service. Staff completed assessments of need to ensure the service could manage their care and support needs. Care plans were developed after an assessment. These gave staff guidance on the support people required to meet their assessed needs safely.

The registered provider had a system in place for people to make a complaint about the service. People and relatives told us that they knew how to make a complaint about the service and care they received.

The registered manager understood their responsibilities in relation to their registration with CQC. Staff we spoke with told us that they respected the registered manager who listened to and acted on their concerns. Internal audits were completed by staff to monitor and review the quality of service provision for people using the service, however these audits had failed to identify and address the shortfalls we found during the inspection.

We found that the service was in breach of the regulations related to safe care and treatment, nutrition and hydration, staffing and good governance. You can see what action we have 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?

Inadequate

The service was not safe.

Risk assessments were not effective because they did not identify and manage some of the risks associated with people's health care needs.

Fire safety was not always managed effectively.

People were at risk from unsafe medicine management. Medicines were not always administered as prescribed.

People raised their concerns regarding staffing levels and told us that there were not enough staff available to support them safely.

Staff were recruited safely to ensure they were suitable to care for people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not fully understand their responsibilities in relation to the Mental Capacity Act 2005 (MCA).

Meals were provided that met people's choices and preferences. However we found that people's nutritional needs and specialist diet needs were not always met.

Staff had a programme of induction, supervision, training and appraisal to support them in their role.

Health and social care professionals were involved in the care of people who used the service when required.

Is the service caring?

Requires Improvement

Aspects of the service were not caring

Staff showed people compassion and kindness while respecting their dignity.

Staff supported and respected people's decisions in their end of life care and support.

Is the service responsive?

Good

The service was responsive

Assessments took place before people used the service. Care plans were reviewed on a regular basis to ensure people's care and support needs were accurate.

People were aware of how to make a complaint about the service.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

The registered manager supported staff at the service and understood their responsibilities in relation to the CQC registration requirements.

The registered manager had a system in place to review and monitor the service. Staff completed regular audits of the delivery of care to monitor the quality of the service. However these had not identified the concerns we found at the service.

Manley Court 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 21 and 24 July 2017 and was unannounced. The inspection team included two inspectors and two specialist professional advisors, one who was a registered nurse and the other a registered pharmacist. The inspection team also included two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that is completed by the provider to give some key information about the service, including what the service does well and what improvements are required. We also viewed the information we held about the service, including statutory notifications received. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people using the service and three relatives. We also used the Short Observational Framework for Inspection (SOFI) to observe the support provided for people at the service. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we looked at 23 people's care records, 10 staff recruitment and training records, 25 medicines records, safeguarding and complaints records, team meeting minutes and other records related to the management of the service. We spoke with 31 members of staff. This included the registered manager, the clinical lead, the deputy manager, a regional manager, 10 nurses, 12 care workers, a maintenance worker, one member of the catering staff, two members of the housekeeping staff and the activity coordinator. Before the inspection we received feedback from four health and social care professionals. After the inspection we received feedback from two health and social care professionals from the local authority and Clinical Commissioning Group (CCG).

Inadequate

Is the service safe?

Our findings

At our previous inspection on 18 and 23 March 2016 we found that the provider had breached the regulations we inspected. The registered provider did not ensure the staffing levels at the service were sufficient to meet the needs of people using the service. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition we found people's care records were not updated and therefore were not accurate. We also found a person's personal emergency evacuation plan (PEEP) did not adequately reflect their needs in the event of an evacuation. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service had mixed views about their safety living at the service. One person told us, "I do feel safe here. I've not seen any bad treatment." However, one person told us, "I don't feel safe in here because of the members of staff. I have a lot of problems with them. They've taken away my call bell but I can call in other ways. We discussed the concerns with staff on duty who assured us they would ensure the person had access to the call bell." We discussed this concern with managers and staff at the service who told us that the person's call bell had been taken away as they used it frequently to call for support from staff. We raised our concern that this person would not be able to summon help in an emergency. The managers told us that they would address this and that staff on the unit would make sure the person could reach the call bell.

We reviewed the home's fire safety processes against the provider's fire safety policy. We found the senior team had ensured compliance in most areas. For example, the smoking shelter in the garden was equipped with a fire extinguisher, a metal sand bucket, a metal ashtray and a fire blanket. Although the smoking shelter was 64% enclosed with plastic or wooden walls, which was higher than the maximum 50% allowed by the provider's fire policy the provider was able to demonstrate that this was appropriately risk assessed as it enabled people to be protected from inclement weather.

People who smoked had risk assessments in place that contained information to support them to stay safe and people were only allowed to smoke in a designated area of the garden which we saw being used during our inspection. The risk assessments included a check of whether each person could safely extinguish cigarettes themselves. Staff had also documented a safety briefing for each person that included a mental capacity check, an observation of smoking technique in case staff could support the person to be safer and a check of clinical risks such as mobility problems. Staff issued people who smoked with safety equipment including a smoking apron and a nurse call pendant when they did not want to be escorted to the smoking area. We saw staff conducted a monthly review of each person who had a smoking risk assessment and updated this when their needs or abilities changed. We observed four people using the smoking shelter during our inspection. In each case the person was wearing a smoking apron or wore a nurse call pendant. However, risks assessments related to smoking did not always identify and consider all the risks associated with smoking as detailed below.

We noted that two people were prescribed paraffin based creams who were also smokers. The London Fire Brigade has advised care homes to stop using flammable emollient creams especially for people who

smoke. Both of these people had smoking risk assessments in place. However, staff had failed to identify this risk. We also found the registered provider's medicines management policy provided people with the opportunity to bring non-prescription medicines into the home for their use. The registered provider permitted white paraffin based products to be used, both of these products are flammable. We noted that these people wore protective aprons when smoking outside in the garden however there remained a risk from fire. This meant that people were at risk of harm from fire because the registered provider was unable to demonstrate that they had satisfactorily mitigated the risks.

People using E-cigarettes had a smoking risk assessment completed by staff. An E-cigarette is a handheld electronic device that tries to create the feeling of tobacco smoking. The E-cigarette used a liquid that should be refilled frequently. However staff we spoke with raised concerns about the use of E-cigarettes at the service. One member of staff told us, "I don't like to fill the E-cigarette, I don't know what I am doing." Another member of staff said, "There is no information in the person's room to help us refill the E-cigarette." We checked the person's care records. There was no information that provided staff with guidance on how to refill the E-cigarette. A third member of staff told us that one person's E-cigarette was faulty. We went to the person's bedroom with the nurse on duty. We found one E-cigarette was faulty because the charging socket was loose and wires were exposed. Staff had arranged for electrical testing of the equipment of one person who charged their E-cigarette using a USB connector in their bedroom. This resulted in some safety advice for the person; including what they could safely use to charge the device and that it should be switched off when they were sleeping. Staff also told us that people smoked the E-cigarette in their bedrooms at night. This was a fire safety risk. The nurse moved the faulty E-cigarette. We also noted there were a number of electric devices plugged into portable electrical sockets. Staff advised the person often left items charging overnight which was against the registered provider's fire safety policy.

There was no fire safety equipment or eye wash station in the laundry room. However, two fire extinguishers were located outside of the laundry room door.

Throughout our visit the emergency exit on the first floor landing of a stairwell leading from the kitchen to the ground floor was blocked by a power generator, trailing cables and trollies. The equipment was in place due to repairs being undertaken to a faulty lift. However, there were no safety notices posted in the area to redirect people in the event of an emergency. We asked a nurse, two healthcare assistants and a maintenance member of staff about this. All four members of staff told us the stairwell was still in use as a fire exit and they would use it in an emergency. This presented a significant safety risk due to restricted access, trip hazards and the use of an electrical generator. In addition, there was only one fire exit sign. This was visible from only one area, which meant in an evacuation, occupants would only be able to see the signed fire exit route if they were in this area. However, the latest fire risk assessment from March 2017 noted fire exit signage to be satisfactory.

We found the door to the passenger lift control and power supply room was unlocked throughout the first day of our inspection. This room was labelled with a large sign that stated, 'Fire door keep locked. Access forbidden to all unauthorised persons.' Inside the room we found the electrical fuse box for the lift was unlocked and open, with easy access to high voltage switches and wiring. The box had a notice attached that stated, 'Access should only be by lift engineer.' This presented a safety risk to people who lived in the home or visitors who could readily access dangerous equipment. We raised our concerns with the deputy manager who told us they would look into these concerns. On the second day of the inspection we found that the door was locked.

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

All three stairwells were equipped with an evacuation ski sheet for use in an emergency. This device enables staff to safely evacuate people who have reduced mobility down stairs without risking injury to them. We asked four members of staff about the ski sheets. Each individual could explain how they would use them and said they had completed practical training in their use.

Staff completed assessment forms to identify actual and potential risks for people on admission in relation to areas such as neglect, isolation, dehydration, abuse, malnutrition, insomnia and poor vision. However we found that plans were not always put in place to manage these identified risks. For example, people risk assessed for isolation had no time scheduled in their care plan for interactions and the evaluations did not state whether they engaged in conversation during care or at any other specified times. In order to see whether people received any interaction staff checked the Activity and Interaction Recording Log which is completed by the activities co-ordinators. However nurses and other members of care staff had not documented what they did to ensure people did not feel isolated.

Staff had received training in medicines administration and had their competency assessed in line with the provider's policy on safe medicines management. However we found medicines were not always administered safely. We observed a member of staff administering people's medicines and saw that they had dispensed medicines for three people into three medicine pots. We looked at the three medicine administration records (MAR) for these people and found the MAR had already been signed before they had received their medicines. We observed another member of staff during lunchtime medicine administration. We noticed the member of staff signed the MAR for two people before they received their medicines. Therefore, we found that staff had not taken action to follow the registered provider's medicines management policy regarding the management of MAR. We also found staff had not followed guidance from the Nursing and Midwifery Council (NMC) Standards for Medicines Management. This guidance states records relating to medicine administration should be completed as soon as possible after administration.

We also spoke with a relative of a person who required specific support to swallow their medicines. The person's relative told us that staff were not providing this support which was having a negative impact on their health. We spoke with the registered manager about this concern. They advised us they would investigate this concern and update us. We had not been updated by the registered manager at the time of writing this report.

We found that people's records were not always updated when changes took place in relation to their medicines to ensure they were administered as instructed. For example, following the review of a person's treatment at a multidisciplinary team (MDT) meeting, it was recommended their medicines no longer needed to be crushed. We checked the person's MAR and found that guidelines to direct staff to crush their medicines were still in place and had not been updated. We spoke with the nurse on duty who confirmed they had crushed the morning doses. However when we spoke to a senior member of staff they confirmed that they were aware the crushing protocol was no longer in place.

We found inconsistencies between the medicines in stock and those administered. For example, there were 10 doses of a medicine booked in however we saw 11 doses had been signed as administered. We saw five examples where people's allergies had not been recorded on their MAR chart. There were five examples where there were inaccurate medicines balances recorded on people's MAR. We saw an example that showed that the prescribed weekly medicines patch for one person was signed as applied on the 10 July and 15 July 2017. When we asked staff about this they told us that they did not know whether there was a recording error or whether staff had reapplied the patch. We found another example where the balance of warfarin in stock on two occasions did not match what had been administered. The deputy manager was informed of this error but could not provide an explanation.

Medicines were not always stored safely. We found that the pharmaceutical fridge temperatures had a higher than expected reading between 9 and 13 of July 2017. The deputy manager confirmed they had sought advice from the dispensing pharmacy regarding the impact of this on the medicines stored. We requested copies of the pharmaceutical advice received from the pharmacy but at the time of writing this report, we have not received this information as requested. We also found that as required medicines were not stored according to the manufacturer's guidelines. For example, we found a tube of ointment stored in someone's bedroom that should have been refrigerated. This meant there was a risk that people had received medicines that may not have been effective because they were not stored according to the manufacturer's guidelines.

We found that medicines and medical equipment were not always safely disposed of. We found where the medicines trolley was stored that two sharps units were full with no lid attached and discarded needles and lines were visible. Sharps units are used to dispose of sharp objects such as used syringes and needles. We immediately informed the senior nurse of this and they sealed the units. There were processes in place to safely manage PRN (when needed) medicines and homely remedies (medicines that can be obtained without a prescription). However we found when two people had medicines administered when needed there was no PRN protocol in place for them.

The issues above relating to poor medicines management were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that the service was not always cleaned to reduce the risk of infection effectively. We completed general observations of the cleanliness of the service. Although some areas of the service were clean, this was inconsistent. We observed the dining room on Hibiscus unit had layers of dust and/or dirt on some surfaces, including cobwebs on the windowsill and a broken hand towel dispenser hanging from the wall. We saw staff had hand washed plastic cups used for drinks but some were still stained or dirty after being washed. Despite this staff used them to give people drinks. We alerted the staff to our observations and staff washed them again before using the cups.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

The registered manager did not always have enough staff deployed to support people safely. The provider used a dependency tool to assess the number of staff required to work each shift to meet people's care and support needs. We looked at the staff rota for the last four weeks and found that the service did not always have the recommended numbers of staff on duty. This was because of short notice absences which the registered manager was unable to cover during those times. Four members of staff we spoke with said that there was insufficient staffing during the day and at night. Staff gave an example where one person living at the service would need the assistance of all care staff on duty on the unit. Entries in the person's care records confirmed that all staff on the floor provided them with support. This meant that if other people on the floor needed assistance there would be no staff available to provide this.

We saw another example where there were not enough staff on duty to support a person to meet their needs. Their care plan stated that a member of staff should accompany them when they wanted to go out in the local community. This person enjoyed going to the local shops to buy certain items. Their risk assessment showed that they were at risk of a fall from their wheelchair as this had happened previously when they went out of the service alone. On the day of our inspection we noted that the person went out of the service without the support of staff. One member of staff told us, "No, [person] goes out alone. We don't have enough staff on duty to provide support to him/her outside and also care for the numbers of people we

have living here." We spoke with the person and they told us, "Sometimes I want to go out, but there's no staff to take me out. I go out [on my own] about once a week, but I ask every day and they say they don't have enough staff." Another person told us, "Shortage of staff and quality of care are abysmal, especially at night. You ring the bell and no one comes. Last night I was told to stop pressing the bell. I was told the nurse was busy because a poor man had wandered out into the night and she's calling the police that was the night before last". This meant that people were put at risk of harm because insufficient staff were available to care for people and keep them safe.

These issues were a continued breach of regulation 18 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Where people were at risk of developing pressure ulcers this was managed appropriately. People were supported to reposition at regular intervals where they were unable to do this themselves and this was accurately recorded. The turning charts we looked at were completed consistently according to the stated frequencies. The documentation clearly described whether the skin was intact or not and which side people were last turned on to. When people needed support with wound care this was carried out effectively. The wound management records for people were completed clearly describing the clinical actions taken to clean and dress people's wounds. Advice was sought from specialist staff for wound management if needed.

We saw that where a person had complex needs, including conditions that resulted in aggressive behaviour, staff worked with specialist multidisciplinary teams. For example, a specialist mental health team and psychologist had supported staff for an extended period of time to find a more appropriate home for a person who demonstrated high levels of aggression towards staff. Staff had also worked with another person to identify triggers for aggressive behaviour. As a result staff had implemented strategies to reduce the likelihood of aggression such as playing the person's favourite music during personal care and maintaining a pain patch prescribed to the person.

The provider's recruitment processes ensured staff were recruited safely. Staff interviews took place to assess their suitability once they had submitted an application form and pre-employment checks were completed. This included requesting previous employers' references, identification documents and explanations for any gaps in employment. A Disclosure and Barring Service (DBS) check was carried out on newly employed staff. The DBS helps employers make safer recruitment decisions and to prevent unsuitable people from working with vulnerable groups.

Staff understood how to identify signs of abuse. Staff we spoke with described what they would do if they suspected someone was being abused or was at risk of harm. The registered provider had a safeguarding policy and process in place and staff followed these procedures to keep people safe from harm. Staff said they were encouraged to use the whistle-blowing policy to raise concerns about aspects of the service or care that had not been dealt with. Staff we spoke with were confident about how to whistle-blow if needed.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 18 and 23 March 2016, staff were not properly supported and supervised to ensure they were effective in their roles. Staff did not receive regular appraisal and supervision. Records showed that some staff had no supervision for six months. Staff were not provided with regular one to one meetings to discuss their performance and to reflect on their practice in order to be able to carry out their duties as required. This was found to be in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the registered provider had made improvements to meet this regulation. The registered manager provided staff with regular support. Staff had access to regular training which was relevant to their role and this included mandatory training in safeguarding, medicine management, basic life support and infection control. Staff records showed that all mandatory training had been completed by staff. Staff had an annual appraisal of their performance which provided them with the opportunity to discuss their personal and professional development needs. Staff records showed they had regular supervision which allowed them to discuss their daily practice and any concerns they had in their role. Staff we spoke with told us they were happy working at the service because they enjoyed caring and supporting people.

Staff did not fully understand and care for people within the principles of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that one person's MCA assessment was not updated to reflect their abilities to make decisions for themselves. We also found that two people had an assessment to self-administer their medicines when their capacity assessment stated that they were unable to make decisions relating to their care and medicines. Therefore records did not always accurately reflect people's capacity to make decisions about their care and support.

In each mental capacity assessment and DoLS application, an appropriate medical or mental health professional had conducted an assessment of the person's capacity. In the DoLS authorisations there was evidence of recent best interests decision assessments. DoLS authorisations related to the need to be in the care home for treatment and clearly stated how long the authorisations should last. MCA assessments were completed by the nurses in respect of the ability to make decisions about care and medicines.

People provided their consent to care and support from staff. One person told us, "Yes. They knock on the

door and always wait until I say come in." All the people we spoke with said that they had provided their consent to care before staff supported them. Care records we looked at were signed by either the person using the service or their relative (where appropriate) in agreement to the plan of care they received.

We found that staff did not always understand people's nutritional needs particularly when they required PEG feeding or were on a specialist diet. A PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. The instructions for the care surrounding PEG feeding was quite comprehensive and the typed sheet was inserted into people's care records. However no risk assessments for PEG feeding were seen in the care records. The amount of water to be given via the PEG tube and for flushing the tube was prescribed on the MAR charts, but there were no fluid balance charts to monitor this. One person told us, "I'm on PEG feed and it's needed at nine o'clock and it's 10.30 or 11 pm. I help them out during the day and it's not my job. They wake me up to show them how to work the machine and I get tired. They woke me up at four o'clock this morning. When we have agencies it's a nightmare. One staff hasn't got a clue."

We found where people had a specialist diet staff did not always offer meal choices. People and their relatives shared their experiences of the pureed meals. One relative told us, "[My family member] has puréed food but the portions are too large and there's little choice. I was told 'We can't purée lots of different meals'. And then they don't seem to understand purée "[My family member] sometimes chokes on the skins of the peas. I think the staff put too much thickener in the liquids – it won't run through the drinking spout. That's why I come in every day and try to be here at all mealtimes. They never offer salt and pepper and there's none on the trays. We've never seen the alternative or light meal menus." Another person told us, "They never ask about portions. I've been here three weeks and they told me the cook would come and talk to me but I haven't seen anyone yet. It's total chaos in the dining room at mealtimes."

These issues were a breach of regulation 14 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Staff used a microwave to reheat cooked food, including battered fish, without checking its temperature. There was a food temperature recording chart on display in the dining room and staff had consistently completed this on each day in the two weeks prior to our inspection. After our inspection the manager clarified the process for ensuring food was of a safe temperature. They said the catering team completed this when the food was delivered.

People we spoke with told us they enjoyed the meals and had no concerns about getting drinks and snacks when they wanted them. There was a menu available so people could choose what they wanted to eat. Menus were posted on the wall in the corridor as a reminder of the meals available on the day. One person told us, "The quality of food is good but it's stodgy and I'm always getting mashed potato. They come the day before and ask me what I want." Another person told us, "There's plenty to eat and drink. The food is good." We visited each dining room in the home. People were able to choose where to sit and the tables were laid with cloths, flowers and a menu, advising that allergen information was available on request. There was a hot drinks machine and a soft drink vending machine that people could use. Dietary needs in relation to culture and religion were included in people's initial assessment. We were told that kitchen staff provided food from different cultures on certain days and that anyone could choose to eat these dishes if they wished to.

We completed observations at lunchtime and the outcome of these was mixed. On one unit staff were attentive, chatty, and affectionate and clearly knew people's individual needs and food preferences.

However, on the first floor of the service we saw staff were very busy during lunch and the service was uncoordinated, with incorrect meals being given out then returned as some staff did not know people's nutritional needs. Dining tables did not have menus on them and staff did not offer people a choice of what to eat. The speed at which staff served lunch meant some people had not finished their main meal before being offered dessert without asking if they were finished or if they wanted more time. This meant people either stopped eating their main meal to eat dessert or had to eat their dessert cold because it had cooled down by the time they got to it. People sat for 15 minutes before being offered juice or water and two people had to ask for napkins as staff kept these and did not routinely give them out. After all meals had been given out, staff sat with people who needed support or encouragement to eat. This included a person who was anxious and needed reassurance about where they were. Staff provided this with compassion and kindness and we saw senior staff supported them with this. We spoke with one person about their experience of meals in the home. They said, "There's a great choice and I'm always happy with the menu. The chef will take last minute requests. Their pastry and fish is always fantastic."

Malnutrition Universal Screening Tools (MUST) and Waterlow scores were completed for each person and weights were monitored more frequently if required for those who were at risk of weight loss. A MUST screening tool is used to identify people who are at risk of being malnourished. The Waterlow score gives an estimated risk for the development of a pressure sore. Beds were seen at their lowest levels and crash mats were placed beside them for people at risk of falling out of bed. Those who were fully mobile and at risk of falls were given enhanced care, extra staff assigned to be with them at all times.

At the time of our inspection the service lift used to transport food from the kitchen to other floors of the home had been out of service for several weeks. This meant staff had to manually carry large quantities of food and catering equipment downstairs before being able to serve it. The care team and catering team managed this themselves without additional staff, which resulted in a delay to the lunch service. For example, we saw some people were seated in the dining room for 35 minutes before they were able to eat.

People had support to attend to their medical appointments as required and were supported to manage any health conditions. However, where a multidisciplinary team (MDT) was involved in care planning it was not always evident that information was appropriately shared. For example, staff had obtained an electric wheelchair for one person with reduced mobility to help them access the garden and to visit relatives. A health professional had trained the person in the safe use of the wheelchair in the streets nearby the home and found them to be competent in its use. However, a GP had noted in the person's care plan that they did not have the mental capacity to safely operate the wheelchair alone. This was contradicted by a care plan review one month later in which care staff documented the person had the ability to make their own decisions and to leave the home if they wanted to. There was no evidence of communication between different staff members and so it was not clear which professional's assessment care staff would consistently follow. We discussed this concern with the nurse in charge. They told us that staff should follow the guidance in the care plan that had been reviewed recently.

Staff completed regular assessments and reviews of people's needs however we found that staff did not always take action to monitor people's support needs to help them maintain their health. For example, people who had long-term urinary catheters, had no record of their urine output. It is good practice to monitor the urine hourly to determine the amount, colour and whether there was any sediment in the urine. This would also indicate whether people needed to increase their fluid intake. Entries stated 'good urine output, bag emptied' and 'urine OK'.

People's care records did not describe their oral hygiene needs. This included whether their mouth was dry, whether the tongue is coated or not, whether a person is able to brush their teeth and whether anything was

applied to keep the lips moist. One person who was on PEG feed and smoked complained of a dry mouth and was prescribed artificial saliva. A care plan for mouth care was subsequently started and the person was comprehensively risk assessed for smoking, being encouraged to use the smoking vest and reminded not to smoke in their bedroom.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and attended to their needs with understanding. One person said, "Staff were very caring." Another person said, "There's a nurse I really adore. She's the most caring person of all." During our general observations of the service we found staff being kind to people and their interactions with them indicated that they knew each other well. One person said, "I am happy here and I speak to all staff. Some of them speak my language from home. We greet each other – first name terms."

Despite these comments we observed some staff behaviour that was not caring. The manner and tone of voice of most members of staff we observed was friendly, calm and respectful when speaking to people. However during our lunch observation we noted one member of staff did not always use an appropriate approach. For example, one person was disorientated and repeatedly said they did not know where they were. The member of staff said, "Your [relative] removed you from the last place you lived and brought you here." Their tone of voice and the words they used were not reassuring and they told the person this in front of other people in the dining room, which was not a private area.

In addition some people seated themselves at a table at lunchtime only to be moved by a senior member of staff when they attended. They told us this was because some people would become agitated with each other during lunch. However, we saw staff moved people without explaining what they were doing or asking them if they were happy to move.

One person we spoke with was positive about the attitude of staff. They said, "Members of staff often come and talk, just have a chat. I always enjoy these. We had a cooking class last week and I learned how to make biscuits. It felt good to learn a new skill and to keep the mind active," We also observed staff had a familiar and informal relationship with people on the first floor. We saw this helped to make people feel at home, relaxed and to ask for help when they needed it.

People told us that staff were helpful and considerate and provided support to them. One person said, "They always get me a cup of tea when I want. Since I came here I feel like I'm free. I've been invited on outings. I'm well looked after and I'm sleeping much better." Another person using the service told us, "There is one carer who comes and talks to me." A third person said, "There are about five members of staff who do look after me. One, a woman, is fantastic."

People were involved in making day to day decisions about their care and support needs. Staff supported and respected people's decisions in their end of life care and support. People had care plans in place for the end of their lives. Where people had requests at this time they were recorded. For example, some people preferred to remain at their home at the end of their lives. Others had funeral arrangements in place and again this was recorded and staff had access to this information when required.

Care records had information on how people wanted to be supported at the end of their lives and who they wish to be involved. We observed staff speaking to people in a caring manner, they leaned towards them when speaking and were friendly when interacting with people.

Staff acted in a way to reduce people's anxieties and concerns. We observed one person who was upset. They displayed behaviour that was challenging to the service. They shouted at a member of staff who remained calm and polite throughout the exchange. The nurse went to the person and spoke with them in a calm manner. This action helped to diffuse the situation and calm the person down.

People appeared well cared for. People were able to maintain their physical appearance and had access to a hairdresser if they requested this. People's personal space was well decorated and items such as photographs of their family were displayed in their rooms. We observed that people's bedrooms were clean and tidy.

People told us their privacy was protected and they were treated with dignity and respect. Each person spoken with told us staff knocked on the door before entering and that they could go to bed and get up at the times they chose. We observed that staff provided care and support to people in privacy when required. We saw staff respond to a person when they used their call bell to ask for help. We observed the member of staff adjust the bed for the person and rearrange their pillows in a caring manner, so they were sitting up more comfortably. While the member of staff was completing the task they were also chatting to the person about a programme they had watched on the television earlier in the day.

Good

Is the service responsive?

Our findings

People shared mixed views on whether their care and support was responsive to their needs. One person told us, "I got up today at half past 11. Kings have said I have to sit up as much as possible. It's written in the care plan and that's what happens". Another person said, "Never had anything to do with a care plan." A third person said, "Social worker showed me the care plan. I've not been asked about my Care Plan, but I know there is one" and "I know there is a Care Plan and I'm surprised I've not been asked to contribute."

People had an assessment of their needs. This provided staff with sufficient information to establish whether a person was able to live at the service. This information also allowed staff to plan the person's care in an appropriate way including the support they would need if they came to live at the service. We found staff completed a number of assessments with people and their relatives or health and social care professionals were involved in the assessment if required. The assessment also provided the person to provide staff with information about themselves. This additional information included their likes, dislikes and their life histories. This was recorded and used to help develop a meaningful and person centred care plan. We found assessments and care plans placed people at the centre of them.

When people lived at the service their care and support needs were reviewed on a regular basis. This involved the contribution of the person using the service and their relative or friend. When changes in care needs had changed, this was reflected in a new and updated plan of care. This meant staff had the most relevant and accurate information of people's needs.

When people's care needs changed following a care review, additional support and advice was sought. Staff had access to a multidisciplinary team (MDT) that visited the service on a regular basis. The MDT meetings discussed people using the service who may be in need of specialist support. However, we found that where a multidisciplinary team was involved in care planning it was not always evident that information was appropriately shared.

People had an evaluation of the care and support they received during the day. Records were made of significant events that happened for people. An example of this would be if a person had a hospital appointment that day or went out with a relative. Members of staff wrote their evaluations mainly at the end of the shift and recorded what people had done throughout the day. However we found one record that a person was unable to communicate because of cognitive issues. There was no information recorded that described how the person was supported to communicate their needs and what methods were used to communicate effectively with them. We saw another person's care record that described the person had soiled themselves and the actions staff had taken to make the person comfortable. However there was no follow up entry to explain or investigate how the person became soiled and whether this was through acute ill health.

People were encouraged to participate in activities that met their needs. Each unit had a dedicated activities coordinator who arranged a variety of activities for people, which everyone could contribute to. These included visits from an animal therapy zoo whereby trained staff supported people to handle animals

safely. Staff told us this was highly beneficial as it encouraged people to interact with each other and contact with animals helped to reduced anxiety and loneliness. Activities coordinators planned for the year ahead by meeting with people in January and asking what they would like to be arranged. We saw evidence that staff used this to create an activities programme that met people's preferences. For example, in January 2017 people who lived in the home told staff they would rather have more frequent outings than a summer fete. As a result staff arranged visits to castles, beaches and cultural events.

Staff supported people to maintain relationships with their friends, family and other people who were important to them. People were able to have visitors at the service. One person told us they were satisfied with visiting arrangements. They told us, "My daughter can come whenever she wants." Another person said, "I like it when I get contact with my family. Visiting times, they come when they like." The registered manager provided an environment where visitors were made to feel welcome. Staff we spoke with told us that friends and family visited on a regular basis and when they chose. During our inspection we noted a number of visitors at the service.

The home environment was spacious for wheelchair users to move freely without restriction. There were noticeboards with information displayed regarding activities which were available 7 days a week, resident meetings, trips out and the menu. There were pictures on the walls, and cushions on seating areas in corridors. The home had some dementia friendly features such as bold, differently coloured doors defining different usage. Bedroom doors were one colour, bathroom/toilet doors another and communal rooms were white. Communal doors were labelled with their use, such as dining room, lounge, toilet, tea room etc. People's bedroom doors were numbered and most also had their name on them.

We saw staff worked with the relatives and friends of people in the home to encourage them to socialise and take part in activities designed to reduce the risk of isolation. For example, an activities coordinator found that by inviting the family members of one person to an outing, the person became much more engaged and reduced the time they spent alone and isolated. Members of staff had developed strategies to support people who experienced anxiety and disorientation. For example, one person experienced confusion and some memory loss and often thought they owed people money, which caused them distress. To help reduce this, staff had obtained printed replica money, which they gave to the person when they were experiencing confusion. We observed this in practice and saw it had an immediate calming effect on the person.

The registered provider had a system in place for people to make a complaint. People were able to raise concerns if they were unhappy with an aspect of their care or the service. There was a complaints process embedded in the home and people were encouraged to discuss any concerns they had with the registered manager or staff when needed. People using the service and their relatives were encouraged to make a formal complaint if they wished.

We found complaints made were managed appropriately. One person told us if they wanted to make a complaint about the service, "I would start with (staff). So far I've nothing to complain about apart from the opening and closing of the main door. People can wander out sometimes." Another person said, "I did make a complaint to the registered manager and it was handled well. It seems to be adequately staffed and I think it is well-led and well organised." We found that the service managed complaints about the service appropriately and responded to the complainant following staff investigation into the complaint.

Requires Improvement

Is the service well-led?

Our findings

We found that the service was not always well led to ensure people received consistent good quality care. The home had experienced a change in the management team in the year leading up to our inspection. There was a new registered manager and a new deputy manager in post at the time of our inspection. People we spoke with made positive comments about how they saw the service managed. One person said, "The bloke in charge is great. He's very good. Greek, I think." Another person told us, "Both managers talk to me and are easily available. I think the place ticks over very nicely." A third person told us, "He's [the registered manager] interested in the comfort of this place. Every day he walks up and down and says "hello (name)". He doesn't pass without saying "hello." A fourth person commented, "The manager's alright. He's lovely. When he comes in he always says hello and makes you laugh."

There were quality assurance systems in place. Internal audits were completed on the quality of care provided at the service. Staff completed regular checks on the quality of care, food, activities, the home environment and medicines. Following the checks action was taken and the progress of this monitored and reviewed to improve the service. For example, people wanted a change in the time of their main meal and we saw this was acted on following a consultation with people using the service and their relatives. However, the audits had failed to identify the shortfalls we found in relation to fire safety, medicines and nutrition and therefore we could not be assured that the quality monitoring systems were effectively operated to ensure that people were cared for safely and appropriately. This issue was a breach of regulation 17 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

Staff we spoke with were complimentary about the management of the service. We spoke with three members of staff about this who said they felt their transition into working at the home went well and that they had been appropriately supported. For example, a member of the activities team told us the new registered manager had immediately provided them with approval to purchase new equipment and resources for the home, including a new camera, new Christmas decorations and the ability to arrange more group outings. One member of staff said, "When the new manager started he went round to each person in the home and introduced himself. He did the same with all of us [members of staff], which I thought was a nice personal touch and introduction." Staff knew which senior member of staff was their first point of contact if they had a concern or issue for discussion.

Staff we spoke with told us that they felt the management of the service was good. One member of staff said, "He listens to us." Another said, "All the managers are good and listen. The deputy manager and registered manager are good. The regional manager comes into the service; she's like one of us."

We observed a number of interactions between the manager, deputy manager and members of staff. In each case we noted the senior team spoke to staff with respect and offered their support during busy periods.

The home had an initiative where members of staff were trained to improve their clinical skills and completed training in medicines and leadership to become 'clinical Senior Carers. They received increased

remuneration once trained and further remuneration was performance related.

We noted Primrose and Hibiscus units had information boards that included an area for compliments and feedback to be written for staff, people who lived there and visitors. It was not clear if this was an effective strategy to support staff as the manager had written identical generic compliments on both boards. This stated, "Well done for the great compliment." We asked staff about this who said the messages were not typical of the verbal feedback they received from managers, which they said was more detailed and constructive. For example, one member of staff said, "The manager is very keen to make sure outings go well. We debrief after each one and he gives really good feedback on what went well. He also helps us to think about things we might do differently."

Staff attended regular staff team meetings. There were whole staff meetings as well as heads of departments and a nurses meeting. These meetings allowed staff to share information with each other. Staff were able to provide advice and support to colleagues experiencing difficulties. When staff had a positive experience this was also shared with colleagues. This meant that staff had an opportunity to share positive experiences with colleagues.

People and their relatives were able to provide feedback about the service. People made recommendations on the activities provided. We saw the service had taken action on this feedback. The activities team demonstrated on-going positive engagement with the relatives of people who lived in the home. For example, they needed to secure volunteer bus drivers to be able to fulfil a programme of outings for people. To accomplish this, the team arranged for the relatives of people who were interested to complete appropriate training and gain a license to drive a minibus so that outings could take place more regularly. After our inspection the provider noted transport was only arranged through the local authority. We were unable to confirm why staff we spoke with described another process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The registered person did not have effective systems in place to mitigate any such risks to the health and safety of service users receiving care or treatment. Service users were at risk from the unsafe management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not always meet the nutritional and hydration needs of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not have sufficient numbers of suitably qualified, competent, skilled and

experienced persons deployed to safely care for service users.