Bupa Care Homes (CFHCare) Limited

Colonia Court Care Home

Inspection report

St Andrews Avenue
Colchester
Essex
CO4 3AN

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Colonia Court Residential and Nursing Home provides accommodation, personal care and nursing care for up to 123 older people, some of whom are living with dementia. The service is divided into four separate bungalows: Amber Lodge, Paxman House, Mumford House and Bloomfield House. At the time of this inspection there were 98 people living at the service.

The service was last inspected on 23 October 2013 and was fully compliant with all the outcomes inspected.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff had received training in safeguarding people from abuse and understood their responsibilities to report concerns to the manager and outside agencies.

Risk assessments provided staff with guidance about how to support people living in the service and effective procedures were in place to monitor the safety of the environment and ensure that people received their medicines safely. However, we found that there were not always sufficient staff on duty to provide safe, person centred care and staff told us that at times they felt rushed and that the care provided was task focused.

The service had a robust recruitment process which ensured that staff were recruited safely and an induction programme was in place to support new members of staff when they joined the service.

Staff were provided with training and support to help them carry out their roles and increase their knowledge about the health conditions of the people they were caring for.

We found that the service was not consistently working within the principles of the Mental Capacity Act (MCA) 2005 and that where restrictions were in place for people the least restrictive option was not always taken. The MCA and Deprivation of Liberty Safeguard (DoLS) ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements.

People had access to a varied and healthy diet. Nutritional assessments had been completed for people and we saw that where appropriate staff supported people with their eating and drinking. However, we had some concerns that staff were not recording the food and fluid intake of potentially vulnerable people.

People had prompt access to healthcare professionals and relatives were pleased that changes in people's

wellbeing were communicated well.

We observed some very caring interactions between people living at the service and staff. Staff were warm in their interactions, communicated well and in general we saw that people were treated with dignity and respect.

There were not always enough activities available to meet people's needs and activities were not personalised. We found that some people had access to a variety of activities and choices of how to spend their day. However other people, especially those who were nursed in bed or who chose to remain in their rooms did not have such a positive experience.

People and their relatives knew how to raise concerns or make a complaint and were confident that they would be responded to appropriately.

Quality assurance systems were in place to monitor the delivery of the service and we saw that where concerns had been raised the service had taken action to resolve the problem and mitigate the risk of reoccurrence.

Staff described the manager as approachable and supportive and told us that they felt valued by the management team. There was an open and honest culture at the service and it was clear that the registered manager was pivotal in maintaining this and creating fluid communication through the service. However, we had some concerns about the lack of support of the provider and the impact that this had upon the people living in the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always sufficient staff to provide person centred care and to meet the needs of people living in the service.

Staff had an understanding of safeguarding procedures and knew what action to take if they thought anyone was at risk of harm or abuse.

Medicines were administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not consistently working within the principles of the Mental Capacity Act (MCA) 2005.

People had access to a healthy and varied diet. However, there were concerns that staff were not recording the food and fluid intake of potentially vulnerable people.

Staff were appropriately trained to enable them to carry out their roles. New staff members were well supported through their induction.

Is the service caring?

Good

The service was caring.

Staff knew the people that they cared for and had developed meaningful relationships with them.

People and their relatives told us that staff were kind and caring to their family members.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were not always enough meaningful activities available to

meet people's needs.

Activities were not always personalised to meet individual people's needs.

There was a robust process in place for responding to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager was supportive and approachable.

Staff felt valued by the management team.

Quality assurance systems were in place to monitor and improve the service.

The provider did not always support staff to improve the lives of people living in the service in a timely manner.

CareQuality Commission

Colonia 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 27 and 28 July and was unannounced.

On the first day of the inspection the team consisted of three inspectors, an expert by experience and a specialist professional advisor in wound care management. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this incidence their expertise was in dementia care. On the second day of the inspection the team consisted of two inspectors.

During the inspection we focused on speaking with people who used the service and the staff who cared for them. We observed the interactions between members of staff and people who used the service. We spoke with thirteen people who lived at the service, eleven visitors and relatives, five nursing staff, thirteen care workers, one domestic staff, one person from the maintenance team, two unit managers and one visiting healthcare professional. We also spent time with the registered manager and toured each of the units looking at the environmental standards within the service. We assessed how medicine was managed, stored, administered and disposed of and looked at records relating to the use of medicines.

We reviewed the care records and risk assessments for seventeen people who used the service. We looked at five staff files to see whether staff had been recruited safely and looked at complaints and compliments received by the service. We also looked at records that related to how the service was managed such as staff rotas, staff training records, a range of audits and the results of quality assurance surveys.

Before the inspection we reviewed the information we held about the service including information from previous inspection reports and statutory notifications the provider sent to inform us of events which affected the service. A statutory notification is information about important events which the provider is required to send to us by law. A provider information return form (PIR) was sent to the provider and completed and returned within the required timescale. This is a form that asks the provider to give some key

information about the service, what the service does well and improvements they plan to make. The information contained in the PIR reflected our inspection findings.

Some people living at Colonia Court could not easily give us their views and opinions about their care. To help us gain a better understanding of people's experiences of living in the service we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Colonia Court. One person told us, "They are lovely girls with lovely smiles. I do feel safe here." Visitors said they had no concerns about the safety of their loved ones and that they would be happy to talk with staff if they had any worries or concerns.

Systems were in place which were designed to protect people from abuse. Staff had completed training in safeguarding and understood the procedure they would need to follow in order to keep people safe from harm. Our discussions with staff showed evidence that they were aware of indicators of abuse and knew how to report any worries or concerns both within the service and, if necessary, to external organisations.

There was a whistle blowing policy in place. All the staff we spoke with were aware of the policy and told us that they would be confident reporting any concerns about the safety of people or the behaviour of other staff members.

Risk assessments were in place to provide staff with guidance about how to support people correctly and keep them as safe as possible. Assessments included, risks related to mobility and falls, bed rails, weight, nutrition, health and hygiene and the prevention of pressure areas. One person displayed erratic and unpredictable behaviour. Their risk assessment stated that staff should check on the person every 30 minutes and there was evidence to show that this was happening. Another person had bed rails in place; we saw that a risk assessment had been completed in relation to this. It was clear that staff had involved the person in the decision regarding the use of the rails and that the potential risk factors surrounding their use had been discussed with the person. The risk assessment was reviewed each month by one of the nursing staff. We also saw that a person had been assessed as requiring the use of a hoist to move them from bed to chair. Their care plan contained detailed information for staff about the process to complete this manoeuvre, including what size sling the person had been assessed as needing.

Weekly clinical risk meetings were held on each unit to enable staff to highlight and discuss areas of potential risk including; new admissions to the unit, tissue viability, nutrition and hydration and any medical conditions that may impact upon people's care.

Some people required pressure relieving mattress to help manage their skin integrity. We saw evidence that daily checks were made to ensure that the mattresses were being used correctly and that they were set at the correct pressure.

Each care plan contained a dependency assessment document which was used as a guide to calculate staffing levels. The manager told us that staffing levels were reviewed on a regular basis to ensure there was sufficient staff available to meet people's identified needs. However, people and staff told us that there were not always sufficient staff to support people and provide safe, person centred care, especially in the morning. One relative told us, "Sometimes though, I don't think there are enough staff here .They seem to be very short each morning getting everybody up, washed and dressed". One person, who chose to eat their meals in their room, told us that at breakfast there was only one member of staff serving both people in the

dining area and people in their rooms. They went on to say that this meant that they often did not get their breakfast until mid-morning. Staff across the service told us that at times they felt rushed, that care was task focused and that they found it difficult to safely observe all of the people who required close monitoring, especially in the mornings.

Activity staff were employed by the service and came onto each unit for a short period of time each day to lead an organised activity, except for the weekends when there were no activity staff on duty. When the activity staff were not on the units care workers were expected to provide activities for people. Staff on all the units told us that in addition to their day to day responsibilities it was not always possible to provide meaningful activities for people. We observed that people who were nursed in bed remained in their rooms with little meaningful interaction, stimulation or activity to keep them active and engaged. On Mumford House there were three people who were cared for in bed. We observed that they were left alone for long periods of time with little interaction from staff other than to attend to personal care tasks. We looked at the daily activity records for these people for this year, the only recorded entries were, 'chatted with 'and 'chatted to whilst feeding'.

The service kept a record of accidents and incidents. Staff completed an accident or incident form for each event that had occurred including falls, urine infections and pressure sores. These records were reviewed by the manager each month to look for any trends or changes which may be needed to people's care. Details of action taken to resolve the incident or to prevent future occurrences were recorded. For example, one person had a number of falls recorded due to deterioration in their mobility. We saw that their care plan had been updated to reflect this and appropriate action had been taken to minimise the risk of further falls whilst still supporting the person to mobilise when they chose to.

Safe recruitment and selection processes were followed when recruiting new members of staff. We looked at five staff files; each one contained two references and proof of identity. We saw that interviews had been conducted and the questions asked had been relevant to the post and were well answered by the candidates. Prior to starting employment, new employees were required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people. The service carried out checks with the Nursing and Midwifery (NMC) to ensure that nursing staff were registered with them and staff employed from overseas had provided a copy of their visas to show that they were eligible to work in the country. The NMC is the regulator for nursing and midwifery professions in the United Kingdom.

The service had a policy and procedure for the administration of medicines. We found that medicines were given appropriately and the recording of their administration was clear and concise. We looked at the medicine room in each unit. The rooms was kept locked at all times when not in use and the controlled drugs cabinet located within it, was also locked. The temperatures of the room and fridge were checked daily so that they were within acceptable limits. We looked at the MAR for five people and found that these had been completed correctly, with no unexplained gaps. We saw that there were protocols in place for offering and administrating medicines given to people as required (PRN) and for ordering, returning and disposing of any unused or unwanted medicines.

Each person had a medication profile with allergies listed and we saw that medication was administered in a safe and timely manner. One relative told us, "It is important that my [relative] gets her medicines on time, and they're really good at keeping to time here". We spoke with one person in Bloomfield House about their medication, they understood what tablets they were taking and why. We saw that staff placed one person's medication on a table in a pot for them to take and observed the person from a far. At one point the person left the table to use the toilet, staff picked up the pot of tablets and placed them in a safe place until the

person returned. Where transdermal patches were prescribed there was good evidence of body maps in use which indicated where on the body the patch was placed. This provided staff with the information they needed to ensure the weekly application of this medicine was placed on alternate sites of the body as prescribed to prevent harm to people.

Staff told us that they had received training on the administration of medicines and attended refresher updates. Systems were in place to record medication errors. Staff completed a daily audit of stock and of MAR for missing signatures and the registered manager carried out monthly medication audits on each unit. We saw that when issues had been identified during the audits appropriate action had been taken to address and resolve the problem.

The environment was monitored and assessed to ensure it was safe for people to live in. Radiators and exposed hot water pipes in all the units had low surface temperatures which protected people from the risk of scalding. Plans were in place for emergency situations including a gas leak, a flu pandemic and an outbreak of fire. Each person living in the service had a personal emergency evacuation plans (PEEP) were in place. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency.

A maintenance person was employed to monitor the environment. Each unit had a maintenance book for staff to log any faults or concerns that arose; due to the size of the service the maintenance person also carried a telephone so that they could respond promptly to urgent repairs on a daily basis. We saw that the fire alarm, emergency lighting and moving and handling equipment were all regularly monitored and checked to ensure that they were in safe working order.

Records showed that actions had been taken, such as descaling, flushing and the inspection of the water system, to prevent legionella and personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order. All taps in the communal areas were fitted with Thermostatic Valve Controls and the water temperature was checked on a monthly basis and recorded as being within a safe range. Where appropriate the company used external contractors to audit and ensure they met the legal requirements to keep people safe. Workplace inspections and audits had been completed by the manager to ensure that the environment was as safe as it could be for people living in the service. Environmental risk assessments were in place and were compliant with the Control of Substances Hazardous to Health (COSHH) regulations (2002). The purpose of the COSHH regulation is to protect people from exposure to harmful substances such as chemicals, fumes and gases. Risk assessments were in place for people living in the service who smoked and for people's wheelchairs including monthly cleaning and maintenance checks.

Requires Improvement

Is the service effective?

Our findings

We found that staff were not appropriately monitoring and recording the food and fluid intake of potentially vulnerable people. Care plans did not always reflect people's changing needs, this meant that some people had not been referred for specialist advice to enable the service to support them in the most effective way.

Nutritional assessments had been completed but there were not always systems in place to monitor people's food and fluid intake. For example, on Mumford House unless a person had been assessed by a dietician and staff had been advised to monitor their food and fluid intake this was not being done. This raised cause for concern because staff were not completing food and fluid charts for potentially vulnerable people such as those nursed in bed and we therefore, could not be sure that people on the unit were receiving sufficient food and fluid intake to meet their needs. One person on the unit was observed walking around the unit and garden throughout the day at a fast pace. We observed a person who was constantly mobilising throughout the day. The person repeatedly refused their meals. Despite the increased risk of weight loss for this person staff were not monitoring what their food and fluid intake and there was no recorded evidence that staff were offering the person an alternative if they refused their meal. We saw from a photograph of the person taken in June 2016 that they had appeared to have lost weight. Care records showed that the person had not been weighed since November 2015, staff had repeatedly recorded refused for each of their monthly weights. Despite the fact that they were regularly refusing meals and burning a high number of calories by constantly walking staff had assessed them as being at a low risk of malnutrition. Their care plan did not identify inadequate food and fluid as a risk and no referral had been for specialist advice. The person had been risk assessed in February 2015 in relation to their 'walking around the unit' and was due for review within a year but had not been reviewed. We spoke with the unit manager about this, they told us that they felt that staff were proactive in ensuring people ate and drank enough and therefore monitoring was not necessary. However, we noted that people on the unit had been prescribed antibiotics for urinary tract infections (UTI) and it was not possible to evidence that these were not due to insufficient fluid intake.

This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed and staff told us that they had received training which helped them understand people's needs and enabled them to effectively carry out their roles. Records confirmed that staff had completed training including safeguarding, manual handling, and fire safety and infection control. More experienced staff shared their knowledge and supported colleagues across the service. One staff member told us, "Other experienced nurses are a great source of support and knowledge. They can be asked about anything." The service supported staff to gain additional qualifications. We spoke with one person who the service had supported to complete an NVQ level 5, this is a work based qualification which recognises the skills and knowledge a person needs to do a job. Nursing staff had completed training modules to help to continue to develop their skills and knowledge in a variety of areas including End of Life Care, catheterisation, falls prevention and tissue viability. Oversight of the training was kept by the registered manager, who maintained a spreadsheet identifying when training had been undertaken and highlighting

when updates and refreshers were due. A visiting GP told us that they felt that staff were trained to a high standard which meant that they had confidence in the decisions that the service made about people. They went on to say that the service had a very low hospital admission rate and that if staff called the out of hour's doctors, they know it is serious and responded quickly as the home never called unnecessarily.

Records showed that nursing staff had met with the registered manager, who was themselves from a nursing background, to complete their revalidation process and to set workplace objectives for the year. Revalidation is the new process that all nurses and midwives need to go through in order to renew their registration with the NMC.

There was an effective system in place for managing catheter care and monitoring pressure areas. We reviewed the care plan of a person with a catheter is situ and saw that nursing staff had clearly recorded the frequency that it needed changing, the date that bladder washouts were given and the expiry date and catheter size. This meant that nursing staff were able to provide effective and consistent catheter care. Skin integrity audits were completed on a weekly basis; this included checking that people's pressure mattresses were working and were appropriate for the individual. These regular audits enabled the service to keep an absolute check on pressure injuries and wounds.

However, we reviewed the skin tear policy and found that it was out of date. The policy stated that staff should use steristrips for skin tears however; case studies and expert opinion suggest that adhesive strips are not the current treatment option of choice for skin tears. The preferred treatment choice is skin glue or silicone dressings left in situ as long as possible.

An induction programme was in place for new members of staff. Staff that we spoke with who had recently been recruited felt that the induction had prepared them to work at the service. The programme involved working alongside more experienced staff and completing mandatory training sessions including manual handling, safeguarding, infection control and food safety awareness before staff were able to work on their own.

All the staff that we spoke with told us that they felt well supported by both the unit mangers and the registered manager. Annual appraisals of staff performance had been completed or planned for all staff and provided an opportunity for managers to look at staff's performance and to support them in their continued professional development. Unit managers told us that they had organised supervision sessions with the registered manager approximately every two months and in turn they provided supervision sessions for the staff on each of their units. This was confirmed by staff who told us that they had regular formal supervision sessions and were able to access informal support and guidance for senior staff if required. The manager had a system in place for monitoring the progress of supervisions and performance reviews and determining when these were due.

Some people living in the service were not able to make important decisions about their care and how they lived their daily lives. The registered manager and the manager of each unit understood their responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had completed training in respect of the MCA and DoLS. However, we found that there were inconsistencies in staffs understanding and knowledge about how to support and enable people to make choices about how they wished to live their lives. In Paxman House we saw that a number of DoLS referrals had been made to the Local Authority and that once the applications had been approved the service had written to people's relatives to inform them. We also saw a member of staff walking in the grounds with a person in their wheelchair without their lap belt done up. We spoke with staff about this and looked at the person's care plan, all of which stated that the person was aware of the risks associated with not wearing a lap belt but that they choose not to wear it. A mental capacity assessment had been completed and deemed that the person had the capacity to make this decision for them and staff supported them to do this.

However, in Bloomfield House we found that some people were subject to restrictive practice without an appropriate DoLS application being in place. Some people had patio doors leading from their bedrooms to an outside area. Staff told us that some people's doors were kept locked but that people could go out with staff members if they requested to. Staff told us that the decision to keep a person's door locked was usually made in conjunction with their family. Only three people on the unit had a DoLS application in place and we could not see that a MCA or best interest decision meeting had taken place to support this decision.

If people had appointed someone as their Lasting Power of Attorney (LPA), who this was and in what capacity was clearly documented in their care plans. An LPA is a legal document that allows someone to appoint one or more people to help them make decisions or to make decisions on their behalf.

People told us that they enjoyed the food and that there was plenty of it. The service had introduced a 'night trolley' for each unit with sandwiches, baked beans and cuppa soups to enable people to have access to snacks during the night time period.

We observed mealtimes in each of the units and saw that people's experience varied. In Bloomfield and Paxman House lunchtime was a relaxed and pleasant occasion. People were given a choice of where they wanted to eat their meal and some chose to remain in their rooms. People were able to choose their meal option from a menu and plated up meals were visually presented to people living with dementia to enable them to choose what they would like to eat. We also saw that people were able to choose off the menu if they wanted an alternative to what was offered that day. One person told us, "The food is very good here – there are always lots of alternatives". In general people ate their food at their own pace and chatted with other people and staff. Where people required support to eat this was provided promptly and staff were patient and focused upon the person that they were assisting. However, in Mumford House we observed that there were insufficient staff to provide consistent support to people at mealtimes. The member of staff supporting people with their savoury meal was not the same person who supported with their pudding. This meant that it was difficult for staff to adequately monitor and record what people have eaten. We also saw that one person sat for 45 minutes with ice-cream and strawberries in front of them uneaten. Staff did not appear to be aware of the person's need to either be prompted or supported to eat this and the pudding was taken away uneaten.

Records showed that some people were regularly weighed. For these people, where a significant weight loss had been identified staff had referred them to the dietician for specialist advice and people had been placed onto a fortified diet.. However, we also saw that when people had repeatedly refused to be weighed staff had not been proactive in addressing this issue. This meant that, as identified previously, potentially vulnerable people had not been effectively supported by staff to access specialist advice and support in order to ensure that their nutritional needs were being met.

Meals were prepared in the main kitchen and brought to each unit on heated trolleys. We saw that on Paxman and Bloomfield unit's people with specific dietary requirements, such as pureed meals and people with conditions such as diabetes or coeliac disease had their needs met appropriately. One person in Bloomfield House had been identified as being at risk of weight loss. They had been reviewed by the dietician and a high calorie diet had been recommended and we saw this advice being put into practice at meal times.

People's healthcare needs were monitored effectively and people said they were supported to obtain treatment if they needed it. Relatives we spoke with told us that staff worked well with health professionals to ensure their relations got the best and most appropriate care. People's care records showed that their day to day health needs were being met. For example, in Paxman House one person complained of feeling dizzy when they got up, the person was reliant upon oxygen and we saw the nursing staff checking their oxygen saturation levels to determine if this was the cause for their dizziness. The nursing staff safely assisted the person to mobilise and settled them. One of the nurses then returned later to review the person.

Where appropriate people had access to the healthcare professionals including the optician, dentist, chiropodist and GP. We saw evidence that when necessary people were referred to specialist healthcare professionals such as occupational therapists, dieticians and speech and language therapists (SLT). The recommendations made by healthcare professionals were clearly recorded in people's care plans and we saw the recommendations being put into practice. Records showed that people were supported to attend hospital and other healthcare professional's appointments away from the service.

Good

Is the service caring?

Our findings

People that we spoke with told us that they were happy living at Colonia Court. One person living in Bloomfield House told us, "I love every moment. I wouldn't swap places with the Queen! They look after you and the food is excellent. What more could you want?" Another person said, "They [staff] are more like friends." Another person that we spoke with said, "The staff here are really nice and friendly – lovely people, especially the manager".

Care plans were personalised and contained information for staff about people's life history, likes and dislikes and their future decisions and preferred plans of care. We saw that care plans also contained information which outlined how people liked to spend their day. We saw in one person's care plan that staff had expressed concern that the person was quieter than usual and was becoming withdrawn. The person had pre-existing mental health conditions and staff had contacted the appropriate healthcare professionals to provide support and advice for the person.

Staff were kind and caring to people and it was evident that they knew the people that they cared for. We heard staff greeting people in a warm and friendly manner and saw that meaningful relationships had been developed between staff and people. In Paxman House staff told us how they had helped one person celebrate their wedding anniversary with their husband by preparing a meal on the unit and making a cake for the occasion and how another person had been supported to email and skype family members. Staff an people told us that birthdays were celebrated with a cake baked by the chef and special events were celebrated with a buffet meal whereby relatives were invited, BBQ's and garden parties were also arranged in the summer.

The majority of interactions with people were observed to be caring, considerate and appropriately supportive of people's dignity. Throughout our inspection we saw staff knocked on the doors to people's rooms and communal bathrooms and always waited for permission from people before they entered. In Bloomfield House we heard one person asking a member of staff if they could get something that they wanted from their bedroom, the staff member checked that the person was happy for them to enter their room and asked if the person wanted to go with them before they left and returned with the item that the person had requested.

Amber House was a specialist unit which provided care for people with a diagnosis of Huntingtons Disease, this is a life limitng progressive disorder of the brain which causes uncontrolled movements, cognitive impairment and emotional problems. Nursing staff had completed specialist end of life care training which enabled them to support people and their relatives at this time. Care plans contained people's advanced care wishes and detailed information about how they wished to be cared for. Staff spoke to us about how they were able to carry out these wishes and the importance of the support that they were able to provide to people and their relatives. One relative told us, "The carers are very kind and look after [person's name] very well. I have absolutely no complaints at all – only praise."

Requires Improvement

Is the service responsive?

Our findings

During the inspection a new person was admitted into Paxman House. Staff had obtained a thorough handover from the hospital before the person was discharged, had followed up specialist advice from healthcare professionals and had begun to develop a care plan in conjunction with the person. However, we also found that care plans were not always reviewed and updated to reflect people's changing needs, such as the person referred to previously whose care plan did not identify their risk of weight loss despite the fact that they were burning a high number of calories and were refusing meals.

On each unit we saw that there was a "You said, we did" board, which displayed suggestions that people had made to improve the service and what action had been taken to implement their ideas. As a result of this we saw that on Paxman House a knitting group had been formed. On Mumford House friends and families had asked for more information about their relatives' conditions and a monthly support group had been formed to talk through the various conditions and speakers had been invited from the Alzheimer's society and dementia specialists.

We found that there were not consistently enough activities available to meet the needs of people living in the service. One person told us, "The staff are very good here – there's not much to do though". Another person said, "I'm bored. There's nothing to do. I sometimes go out in the garden when a carer has the time to take me, but they're so busy they never have time". A relative told us, "I do worry that he doesn't do much, but I suppose that's down to money?" In Bloomfield House we saw staff sitting and chatting to people and a variety of activities were taking place including; people playing scrabble; singing and people sitting in lounge chairs and reading newspapers. We also saw that activities including games, book reading in the garden and reminiscence sessions were planned on the other units.

We observed that people who either could not, or did not want to attend the organised activities, had limited opportunities to engage in other interests and we did not observe any one to one activities taking place with people in their rooms. One person's care plan stated that they enjoyed gardening and it was evident that they wanted to be outside because they became agitated and distressed if people tried to stop them. However, during the inspection and from reviewing the recorded activities in their care plan it was not evident that they were being supported to participate in meaningful, personalised activities which considered their love of gardening. The time that activity staff spent with people was recorded individually within their care plans, therefore it was not possible to gain an oversight of how the activities coordinators spent their time and if it was fairly distributed amongst people.

We observed, and staff confirmed, that there were not enough chairs on Mumford House for people who were nursed in bed to sit out of bed if they chose. We saw that two people were sat in portable, reclining chairs. One chair was observed to have several tears in the fabric and was in need of replacement. This concern had also been highlighted during a recent quality audit conducted by Essex County Council.

People that we spoke with told us that they knew had to raise concerns or make a complaint. People had confidence in the unit managers and those who had raised concerns with them told us that they had been

dealt with promptly and effectively. The service had a robust system in place for handling and responding to complaints. We looked at the complaints file and saw that any complaints that had been made had been responded to in writing by the registered manager and, where appropriate, any issues raised had been addressed with the staff and action had been taken to address the problem.

Requires Improvement

Is the service well-led?

Our findings

There was an open and honest culture throughout the service. Staff described the registered manager as "approachable and supportive". One staff member told us, "We've got a really good team here." A relative said, "I get in more or less every day to see her, and I've found the staff very good, and the manager has been very supportive when we've asked her for help". In turn the registered manager recognised the contribution of staff to the service through the 'star of the month' reward, she told us, "I love watching staff develop and grow" and it was evident that she knew her staff well and encouraged and supported them.

Whilst is was evident that the registered manager supported staff and was a strong advocate for people living in the service, we had some concerns that the provider did not react in a timely manner to concerns identified by the service and the impact that this had upon the people living in the service. Staff on Mumford House told us how they would like to improve the environment on the unit in order to make it more dementia friendly. The unit manager demonstrated a good understanding of resources which could support people living with dementia to orientate around the building and improve their quality of life. We were told that several requests had been made for funding to do this however, the provider appeared slow to respond to request for resources that would enhance people's quality of life and meet their needs.

Each unit also had its own manager who was responsible for the day to day running of the unit. They in turn reported back to the registered manager who had overall responsibility for the management of the service. The unit managers were allocated six hours a week of non-clinical hours to fulfil their managerial responsibilities which included completing; staff rotas, staff supervision and appraisals and quality assurance audits. Their remaining hours were used to provide direct care to people living in the service. All of the unit managers that we spoke with confirmed that the non-clinical hours were insufficient for them to complete the required tasks in and that the frequently had to use the time when they should be providing direst care to fulfil these responsibilities.

Staff told us that they felt that there were occasions when corporate decisions that had a direct impact on them were implemented without consultation. Bupa had recently introduced a change to how topical medicines were recorded as administered. Care staff were now expected to inform the senior carer or nurse when they had administered creams and lotions. The senior member of staff was then expected to write on the back of the MAR the time and description of the administration. This meant that the person responsible for administering the medicines did not sign the MAR. This approach was time consuming for staff and meant that staff did not have easy access to instructions as to where the cream or lotion was to be administered on the body.

We also observed that there were several people who remained in bed in Mumford House. When we raised this with staff one staff member told us, "We do not have enough specialist, reclining chairs in the lounge for them." We were told that senior staff had asked repeatedly for funding to purchase some new chairs but this had yet to be actioned by the provider. We spoke about this with the registered manager who told us that the chairs had been ordered in January 2016 but they were still waiting for approval from senior managers to fund them. Following the inspection the registered manager sent us confirmation that that the chairs had

been approved by senior management on 2 August 2016 and were due to be delivered to the service.

Staff felt that communication in the home was good and it was evident that the registered manager was pivotal in ensuring fluid communication across the service. Each unit had daily staff handovers and in additional daily meetings took place at 11:00 between the registered manager and the manager of each of the units. We attended one of these meetings and saw that they were an effective way for the management team to discuss what was happening across the home on that day, including activities, any new admissions, healthcare appointments and provided the opportunity for any staffing issues to be highlighted

Regular staff meetings were held on each unit and the day that they took place were rotated to try and ensure that as many people as possible were able to attend. In addition to this the registered manager also held monthly heads of department meetings during which she met with the deputy manager, clinical lead, unit managers and the head of housekeeping and maintenance. This enabled the senior management team to raise concerns with the registered manager and in turn for her to discuss the outcome of quality assurance audits and the resulting action plans with the team. We looked at the minutes from the heads of department staff meetings and the meetings held on each unit and saw that the information discussed at this meeting was passed down to staff members through the unit managers during their own staff meetings.

The service conducted annual resident, relative and staff satisfaction surveys, the results of which in the main reflected positively on the service. Residents and relatives meetings took place on each unit to give people a chance to provide their views and hear updates on the service. On Bloomfield unit resident meetings were held every three months. We looked at minutes from the meetings and saw that issues and requests raised in the meeting were acted upon. For example, at one of the meetings people had requested to have a bench in the courtyard area outside the unit. We saw that the manager of the unit had raised this request with the registered manager and a bench had been ordered and provided.

There were effective quality assurance systems in place to ensure that any areas for improvement were identified and addressed. We saw copies of the monthly audits and reviews that were completed by the registered manager or the manager on each unit. These included monthly bed rail checks, infection prevention and control audits, medication audits, care plan audits and quality outcome reviews. The registered manager also completed a daily clinical walk around during which they looked at any clinical concerns, hospital admissions, staffing levels, wound or medication concerns and the cleanliness of the service. Any issues that were raised during the monthly audits and observations were responded to and resolved in a timely manner.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs **Staff were not appropriately monitoring or completing food and fluid charts for potentially vulnerable people.**