GCH (South) Ltd

Baugh House Care Centre

Inspection report

19 Baugh Road
Sidcup
Kent
DA14 5ED

Tel: 02086201007
Website: www.goldcarehomes.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 and 27 July 2017 and was unannounced. Baugh House Care Centre is a home providing residential and nursing care for up to 60 older people some of who may be living with dementia in the London Borough of Bexley. At the time of our inspection there were 34 people living at the home.

This was the first comprehensive inspection of the service since it was registered under the provider, GCH (South) Ltd in May 2017. Prior to this the service had been inspected in April 2017 under the previous provider, GCH (Kent) Ltd, at which time it was rated 'Inadequate'. CQC decided that we could only permit GCH (South) Ltd to operate this service subject to a number of conditions to address the concerns found during that inspection. GCH (South) Ltd agreed to accept those conditions on its registration and has complied with their requirements since that time.

There was no registered manager in post at the time of our inspection. The current manager was in the process of applying to become registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified breaches of regulations because records relating to people's medicines were not always properly completed to demonstrate they had received their medicines as prescribed, and because the provider had not always followed safe recruitment practices when employing new staff. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people had been assessed and action taken to manage identified risks safely. However, improvement was required to ensure records relating to the management of any wounds people had were kept up to date and accurate. Improvement was also required to ensure sufficient staff were consistently deployed on each unit at night time to meet people's needs, and to ensure quality assurance systems consistently identified issues and drove improvements.

People were protected from the risk of abuse because staff were aware of the action to take if they suspected abuse had occurred. Staff were supported in their roles through training and supervision and told us they were well supported by the management team. People were able to access a range of healthcare services when needed and were supported to maintain a balanced diet.

Staff sought consent from people when offering them support and the provider worked within the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People told us their privacy was respected and that they were treated in a caring and dignified manner. Staff involved people in day to day decisions about the support they received.

People told us their care and support needs were met. They had care plans in place which had been developed based on an assessment of their needs and preferences, which were reviewed on a regular basis to ensure they remained up to date. The service offered a range of activities for people to take part in and plans were in place to increase the level of activities offered.

The provider had a complaints policy and procedure in place, and people told us they were aware of how to raise any issues they had. Most staff spoke positively about the management of the service, although one staff member highlighted that there had been a series of changes in the manager role and it was too early to have formed a proper view on the management arrangements.

The service had systems in place to seek feedback from people using the service and senior staff confirmed that any feedback they received would be acted on to drive improvements. We also saw action had been taken to address issues identified during checks and audits conducted by staff.

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.

Medicines were not always managed safely. Records relating to people's medicines were not always properly completed to demonstrate they had received their medicines as prescribed.

The provider had not always followed safe recruitment practices and did not always have copies of recruitment information required by regulatory requirements. Improvement was also required to ensure sufficient staff were appropriately deployed to meet people's needs at night.

Risks to people had been assessed and action taken to manage identified risks safely.

People were protected from the risk of abuse because staff were aware of the action to take if they suspected abuse had occurred.

Is the service effective?

Good

The service was effective.

Staff were supported in their roles through training and supervision.

Staff sought consent from people when offering support and respected their wishes. The provider had systems in place to ensure the service complied with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain a balanced diet.

People had access to a range of healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff treated people with care and consideration.

People were involved in day to day decisions about their care and treatment.

Staff respected people's privacy and treated them with dignity.

People received appropriate end of life care.

Is the service responsive?

Good

The service was responsive.

People told us their care need were met. Care plans reflected people's individual needs and preferences and were regularly reviewed to ensure they remained up to date.

People were supported to take part in a range of activities and the provider was in the process of recruiting new activities staff to increase this provision. People were able to maintain the relationships that were important to them.

The provider had a complaints policy and procedure in place and people' were aware of how to raise any concerns they had.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not have a registered manager in place. The current manager was in the process of applying to become the registered manager but there had a series of changes in management at the service and they had only recently been recruited. People were not always aware of the current management arrangements and we received mixed feedback regarding the management of the service from staff due to these changes. However most staff told us they felt well supported in their roles.

The provider had a range of quality assurance systems in place, but improvement was required to ensure these consistently identified issues in order to drive improvements.

Improvement was required to ensure records relating to the management of any wounds people had sustained were accurate and up to date.

People's views on the service were sought through an annual survey which senior staff confirmed would be used to drive improvements.

Baugh House Care Centre

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 25 and 27 July 2017 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience on the first day, with the two inspectors returning to complete the inspection over the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we held about the service and the provider. This included notifications from the provider. A notification is information about important events that the provider is required to send us by law. We also contacted a local authority who had involvement in monitoring the services at this location to seek their feedback. We used this information to help inform our inspection planning.
We did not request that the provider complete a Provider Information Return (PIR) prior to this inspection. This was because the inspection was planned shortly after the service had been registered under a new provider. The PIR 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.

During the inspection we spent time observing the care and support being delivered by staff. Where people were not always able to comment on the support they received, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine people, four visiting relatives and two visiting healthcare professionals to gain their feedback on the service. We also spoke with 13 staff including the service manager, area manager and a project manager based at the service. We looked at records, including 11 people's care records, six staff recruitment files, staff training and supervision records, and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not consistently managed safely. We saw medicines administration records in place for each person which included their photograph and details of any allergies they had to help reduce the risks associated with medicines administration. However, people's MARs had not always been completed correctly by staff to confirm they had received their medicines as prescribed. For example, we found one person's MAR had not been signed on eight occasions to confirm the administration of an antidepressant medicine taken at night during a nine day period in the three weeks prior to our inspection. We reviewed the remaining stock of this person's medicine but the number of tablets left did not accurately reflect that the medicines had been administered to the person as recorded, or as had been prescribed.

We also found stock of another medicine for one person had been prescribed for them to take 'as required', but there was no reference to the medicine on the person's current MAR. This meant we were unable to determine whether the remaining stock of the medicine was correct, or whether the medicine had been appropriately offered to the person if required. Additionally, we noted that a third person had been prescribed a Controlled Drug (CD) to be taken 'as required' but there was no protocol in place to give guidance to staff on the conditions under which the medicine should be offered to ensure it was administered appropriately.

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

People told us they were supported to take their medicines when required. One person said, "They [staff] come round with a big trolley and we are given our medicines; in the morning I have seven pills." Another person told us, "The staff bring my medicines to me. Once it is in my mouth I swallow it." We observed part of a medicines round during our inspection and noted that people were appropriately supported to take their medicines as prescribed.

Medicines were stored securely in locked trolleys which were kept in locked clinical rooms when not in use. Access to medicines was restricted to only authorised staff members on each shift. We saw temperature checks of medicines storage areas had been made on a regular basis to ensure medicines were stored with in safe temperature ranges. The provider had processes in place to receive and dispose of medicines appropriately which had been arranged through a local pharmacist. Records showed that where appropriate, remaining medicines stocks had been returned to the pharmacist at the end of each medicines cycle for disposal.

The provider had not consistently followed safe recruitment practices when employing new staff. We saw examples of appropriate checks having been made on staff prior to their commencing work for the service, including criminal records checks, references, details of their employment history and checks on identification. In one example we noted that senior staff had conducted an assessment where one staff member's criminal records check had identified historic disclosures. This demonstrated that the issues had been considered by the service and assessed as not placing people at risk or affecting the staff member's

suitability for their role.

However, we also found examples of references that only confirmed staff member's dates of employment at other social care services, with no reference to their conduct whilst employed there. Additionally, we noted one staff member's references did not clearly identify the organisation providing the reference so could not be assured that it was suitably robust. We also found examples where staff had not provided accurate details of their full employment histories, and that one staff member had terminated their employment with the service but then returned to work after a two month period without any further checks or consideration made of their time away from the service.

These issues were a breach of regulation 19 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. During the inspection, senior staff provided evidence to demonstrate that they were in the process of following up on the references issues we identified, although this action was still to be completed at the time of our inspection. We will follow up on the action taken by the provider at our next inspection.

People told us there were sufficient staff on duty to meet their needs although we received mixed feedback about how quickly staff responded when needed and one relative was concerned about the high turnover in staff that the service had experienced in the last six months. One person said, "They have pulled in a lot of staff; addressed the staffing levels. Sundays can be a bit of a stretch on staff when it's busy." Another person commented, "I think they are trying to build the place up again. They have more permanent staff which is a lot better. Everything appears to be okay at the moment and I'm hoping it stays that way." However a third person told us, "My balance is very poor and sometimes they [staff] are slow in coming."

Staffing levels were determined based on an assessment of people's needs, and records we reviewed showed that actual staffing levels reflected the planned allocation. We saw that, where required, call bells had been placed within peoples reach so that they could request support from staff when required and that regular checks were made on other people who were unable to use a call bell. One person said, "I have a call bell; if you fall over you shout and you find yourself surrounded by people." Throughout our inspection we observed staff responding quickly to people's call bells when activated and that they were on hand to assist people promptly when required. One staff member told us, "It's nice and relaxing here today, sometimes it can get busy but we I think we always have enough staff on duty to support the residents safely."

The manager confirmed that the service had recruited a number of new staff in recent weeks which led to a reduction in the need to use agency staff who may not always be familiar with people's needs. Whilst we noted that some of the staff on duty had only recently started at the service and so were not fully familiar with people's needs, we saw that they were competent to provide support safely, for example when transferring people from chairs to wheelchairs using a hoist, when required.

However improvement was required because another staff member told us they were concerned that there were only two care staff on duty during the night on one unit, and some people required two staff to support them during the shift. They explained this meant there were no other staff available to support the remaining people on the unit if required. We reviewed a sample of the care plans for people living on the unit. These showed that some people required two staff to support them at night and that other people's sleeping patterns meant that they may also be up throughout the night and potentially in need of support. This meant there may be occasions when more than two staff were required to support people at any one time. Following the inspection, the management team confirmed that they would review the way in which staff were deployed on each unit at night to ensure there were sufficient staffing levels at all times.

Risks to people were managed safely, although improvement was required to ensure records relating to

wound management at the service were kept up to date. People's records included details of completed risk assessments in areas including falls, moving and handling, nutritional needs and skin integrity. We saw action had been taken to reduce identified risks. For example, we saw pressure relieving equipment in place where people's skin integrity had been assessed as being at risk, which was monitored by staff to ensure it was used appropriately. We also saw records confirming that people had been supported to reposition on a regular basis, where this was required to reduce the risk of them developing pressure sores.

In another example, where people were at risk of malnutrition or choking, we saw referrals had been made to a dietician or speech and language therapist (SALT) for their advice on how they should be safely supported. Staff were aware of the guidance that was in place to support people safely. For example, one staff member correctly described the support one person required to eat safely, in line with guidance provided by a SALT after an assessment they had conducted during the week prior to our inspection.

We saw wound assessment records in place where required which described the nature of any wounds people had sustained and how these were being treated. The records we reviewed showed the wounds to be improving and healing over time.

The provider had systems in place to monitor aspects of the environment and the equipment used at the service which included checks on electrical appliances, gas safety, window restrictors, water temperatures, the lift, slings and hoists, wheelchairs and walking aids used by people. These helped ensure people's safety at the service.

There were procedures in place to deal with emergencies. Staff we spoke with were aware of the action to take in the event of a fire or medical emergency. Records showed there had been checks made on the fire systems and emergency lighting and we saw regular fire drills had been conducted to ensure staff were aware of their responsibilities if a fire occurred.

People were protected from the risk of abuse. The home had policies and procedures for safeguarding adults from abuse and whistle-blowing. Staff we spoke with demonstrated a clear understanding of the types of abuse that could occur and how to safeguard people. They told us they would report any concerns they had to the person in charge of the shift, or the manager. The manager told us they were the safeguarding lead for the home and they were aware of the action to take when making safeguarding referrals to the local authority and notifying CQC as required by current regulations. Training records confirmed that all staff had received training on safeguarding adults.

One member of staff told us, "I would report any concerns about safeguarding the senior person on shift. If I thought nothing had been done I would advise the manager or the regional manager. I would tell social services and the CQC if no action was being taken. If I needed to I would use the providers whistle blowing procedure to report poor practice." Records confirmed that the manager had submitted safeguarding referrals to the local authority where required, in line with locally agreed procedures.

Good

Is the service effective?

Our findings

People and relatives told us they considered the staff to be competent in their roles. One person said, "The staff know what they are doing; they never put me in a position where I worry." Another person told us, "I have nothing bad to say about the carers here." A relative said, "We would say there has been some improvements recently; some of the staff are very good." Throughout our inspection we observed examples of staff supporting people in a competent manner, for example when supporting people to mobilise, or whilst eating.

Records showed, and staff confirmed that they undertook an induction when they started working at the service which was appropriate to their roles. Where staff had no, or limited experience of working in a social care setting they were also expected to complete the Care Certificate which is a nationally recognised set of standards forming part of a social care induction. One staff member said, "I had a three day induction; I read all of the residents care files to get to know about them. I am doing my training in line with the Care Certificate and there is plenty more training planned for me. I shadowed an experienced member of staff too. They showed me the routines and how things worked on the nursing floor. They showed me how to fill in observation charts and paperwork."

Records also showed that staff received training in a range of areas considered mandatory by the provider, and this was periodically refreshed to ensure they remained up to date with best practice. One staff member told us, "I have completed training in a workbook and been assessed on what I have done this was on topics such as safeguarding adults, the Mental Capacity Act, fire safety, nutrition, health and safety, infection control, first aid, and moving and handling." Another staff member said, I feel I have a good understanding of how to support people here. For example, I've had moving and handling training, and am now confident when using a hoist." On-going training was also planned for new staff which was appropriate to their roles. For example, new nursing staff had been scheduled to undertake training relevant to nursing older people.

Staff were supported in their roles through supervision and an annual appraisal of their performance. A member of the management team also confirmed they would be providing clinical supervision to the new nursing staff at the service. One staff member told us, "I had supervision with the shift leader. We have lots of group meetings where we talk about specific issues like completing observation charts or health and safety issues. I am very well supported by the nurses and managers. They are always asking me how things are going and if I need anything." A newly appointed senior staff member said, "I have had supervision with one of the management team and I am starting to supervise my staff. I have had some group supervisions where we have put things in place to make improvements. For example I met with the staff group to talk about the use of the sluice room."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff confirmed they were aware to seek consent from the people they supported and we observed examples of staff seeking consent from people when offering support during our inspection. One staff member said, "It's important to communicate clearly; I will always seek consent to assist people and we respect people's wishes." Records showed that where people lacked capacity to make specific decisions such regarding their care or treatment, staff had conducted a mental capacity assessment and any subsequent decisions had been made in people's best interests, in line with the requirements of the MCA and involving people's families, or healthcare professionals, where appropriate. For example, we saw a mental capacity assessment had been made with regard to the use of bed rails for one person and that during the subsequent best interests decision it had been agreed that the less restrictive option to use a low profiling bed was more appropriate so this had been put in place.

Records showed that requests for DoLS authorisations had been made, and authorisations granted by the relevant local authorities to ensure people were only lawfully deprived of their liberty when it was in their best interests to do so. The provider had systems in place to ensure that further applications were made where required on a timely basis where existing DoLS authorisations were due to expire. We reviewed a sample of the DoLS authorisations in place at the service and found that any conditions placed upon them had been met. For example, quarterly monitoring forms had been submitted to one local authority as required.

People were supported to maintain a balanced diet. We received mixed feedback from people about the food on offer at the service. One person told us, "The food it is very good, although we get days when it is not very nice. It has improved since we got a new chef; today it was great." Another person said, "It is quite good most of the time. They are bring me soup in the evening, as I don't like sandwiches." A third person said, "They [staff] all know what we like for dinner and there is plenty to eat."

People's care plans included assessments of their dietary needs and preferences. These assessments indicated their dietary requirements including details of any food allergies or specific dietary requirement or support needs they had. Kitchen staff had access to information about any individual dietary risks people had, as well as their food preferences and any cultural requirements they had.

We observed a lunchtime meal and noted that staff were on hand to assist people where required whilst other people ate independently. The atmosphere in the dining room was relaxed and people were given time to eat their meals without rushing. Some people ate their meals in their rooms in accordance with their preferences. We saw that they received hot meals and drinks in a timely manner. People were also provided with drinks and snacks throughout the day and these were available in the lounges on each unit.

People confirmed they were supported to access healthcare services when they needed them. One person said "Staff will call the GP if I need one." Another person told us, "The doctor comes to visit to see what weight you have put on. I am always alright and don't need to see them much."

Records showed that people were supported to access a range of healthcare services including a GP, community nurse, dietician, speech and language therapist, and optician. We saw guidance from healthcare professionals had been added to people's care plans for staff to follow where required. We spoke with a

visiting phlebotomist who was working as part of the local community nursing team and they told us, "I used to be left alone when I visited to find my patient and to try and treat them and there wasn't always a member of staff available to help me. It's miles better here now than it was before; there is always someone at the door to greet me and show me to my patient. The staff appear to know the residents really well. They provide good support to me and the resident when I am treating them."

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "Yes, the staff are caring; if they see you wondering around they will ask you what you want, and if you are lost in the corridor they will take you to your room." Another person told us, "My daughter is very happy with me here. They [staff] ask all the time how I'm doing, and whether I need any medication, or a drink." A relative said, "The staff are considerate. [Their loved one] prefers the permanent staff to agency, but there are less agency now which is good. We were able to celebrate [their loved one's] birthday here with the whole family; it was lovely, just like being at home."

We observed many examples of staff providing people with good care and noted that people were treated with understanding, compassion and dignity. For example where people were agitated or wanted to stop and talk, we saw staff listened to them actively and encouraged them to communicate their needs. We also observed staff engaging people in meaningful conversations or reading magazines with them. People also confirmed they were treated respectfully. One person told us, "They staff are very patient. I am nice to them; they respect me and I respect them."

Staff described the action they took to ensure people's privacy was respected. One staff member said, "I always knock on people's doors before entering their rooms and will introduce myself and explain why I'm there. If I'm supporting them with personal care I'll make sure the curtains are drawn and the door closed." People we spoke with confirmed their privacy was respected by staff. One person told us, "They [staff] always knock the door." Another person said, "They [staff] respect my privacy; when my family are here they always make themselves scarce." We observed staff knocking on doors before entering people's rooms, and ensuring doors were closed while they supported people.

People's cultural, religious and diverse needs were met. The activities coordinator told us a member of a local church visited the service every two weeks and a priest visited specific residents on occasion in support of their faith. The explained, "We try to cater for peoples cultural needs. For example, in June we held a virtual cruise where we offered people foods from different places around the world, put up flags and landmarks such as the Eiffel Tower. We also celebrate occasions such as St Patrick, St Andrew or St George's days as well as the resident's birthdays."

Staff told us, and our observations confirmed that they consulted with people about the support they required and involved them in day to day decisions about their care. For example, we saw staff offering people choices in the activities they undertook or where they wished to spend their time within the service. One staff member told us, "We try to give people as many choices in their day to day lives as possible, for example some people like to have breakfast before they get washed and dressed and others like to wash first so we give them the option. We encourage people to make decisions themselves in areas such as what they might like to wear or whether they would like to spend time in their bedrooms or in the communal areas."

People were able to maintain the relationships that were important to them. One person told us, "My family

can visit any day." Another person said, "We have lots of visitors." A relative commented, "We're able to visit whenever we want and feel well informed about what's going on with [their loved one's care]." We noted that there had been a recent incident in which one person's family had been asked not to visit the service due to conflicts with the staff. However senior staff and the local authority confirmed that this issue had been further discussed and that the family members were again able to visit their loved one at the service.

People received appropriate end of life care and support. The project manager and a nurse told us the home worked closely with a local hospice for providing end of life care to people at the home. Some staff told us they received training on end of life care from a nurse from the local hospice. An advanced practice nurse from the local hospice told us they had been attending the home every week since October 2016 to offer support to staff with end of life care. They had trained nurses and care staff recently and said they would be providing further training in the next few weeks. They said staff had been supporting people appropriately with care and pain relief.

Good

Is the service responsive?

Our findings

People and their relatives told us the staff met their care and support needs. One person said, "Yes, I can't think of anything they haven't done we have asked." Another person commented, "The support staff give me is very good, I don't have to ask for it." A relative told us, "We're happy with the care; [their loved one] gets the help they need and we have no complaints."

Senior staff told us, and records confirmed that they undertook an assessment of people's needs prior to their admission to the home to ensure the service was able to meet their needs. From these assessments we saw staff had developed care plans and risk assessments which included information and guidance for staff on the support people required to ensure their needs were safely and appropriately met. Care plans covered a range of areas in which people required support including nutrition, mobility, continence, skin integrity and night time support. These had been reviewed on a regular basis to ensure they remained up to date and were reflective of people's current support requirements.

Care plans also included details of people's life histories, as well as information about their preferences in their daily routines and the way they received support, for example when they liked to get up or go to bed, or whether they had a preference for male or female staff to support them with personal care. Established staff we spoke with were aware of people's individual preferences in the support they received and staff who had only recently started at the service told us they reviewed people's care plans to ensure their individual needs were met, and were spending time on their shifts getting to know people on a personal level.

People took part in a range of activities to support their need for stimulation. One person told us, "I do sewing, singing and chatting." Another person said, "I like taking photographs of the birds and squirrels. I can go outside but not if the weather is not so great. They also get singers in here." The home had an activities co-ordinator who arranged activities for people to take part in, although they told us they did not work at the service every day. Activities included morning exercise, coffee mornings, sherry and snacks, sing along, playing musical instruments and visiting entertainers.

During the inspection we observed people playing ball and bean bag games. A group of school children also visited the home to spend time and entertain the people living there. We observed them chatting to people and offered a session on playing drums. The activities coordinator told us they also provided activities to people who liked to stay in their rooms. They said they read books or newspapers and told us that some people just enjoyed having someone to talk with. One relative commented that they thought the level of activities on offer had decreased in recent months. We brought this, and the fact that the activities co-ordinator only worked on a part time basis to the attention of the management team who confirmed they were in the process of recruiting additional activities staff in order to increase activities provision within the service.

The provider had a complaints policy and procedure in place which people had access to should they wish to do so. The complaints procedure included information on how people could raise a complaint and what action they could expect the service to take in response. This included details of the timeframe for

investigation and how any concerns could be escalated to external bodies, if they remained unhappy with the outcome.

People and relatives told us they knew how to raise concerns. One person said, "I would speak with one of the nurses if I had a problem." Another person told us, "I've not had to complain but would speak with the manager." A relative also confirmed they were aware of the provider's complaints procedure and told us they would tell staff or the manager if they wanted to make a complaint. They felt they would be listened to and their complaints would be fully investigated.

The provider's complaints log included a copy of their complaints procedure, forms for recording and responding to complaints and correspondence between the provider and the complainants. Complaints records showed that when concerns about care and treatment had been raised these were investigated and responded to, and where necessary discussions were held with the complainant to resolve their concerns. The provider had also maintained a record of complaints responses that had been sent out to people or relatives in response to matters not related to people's care and treatment.

Requires Improvement

Is the service well-led?

Our findings

The service had a range of quality assurance systems in place to monitor the quality and safety of the service, although improvement was required to ensure these were operated effectively to drive improvements at the service. Records showed checks and internal audits had been conducted on a regular basis in areas including medicines, care planning, call bell response time, infection control, health and safety, and incidents and accidents. We saw action had been taken where issues had been identified in response to audit findings. For example sections of one person's care plan had been updated where an audit had identified that this was overdue.

However, improvement was required because a recent medication audit had not identified the gaps we found on one person's medicine administration records despite the person's records having been checked as part of the audit. We brought this issue to the attention of the manager and they told us they would follow up with staff to ensure similar oversights did not occur in future. However, we were unable to check on the effectiveness of this at the time of our inspection.

The provider also undertook audits and checks covering areas including safeguarding, recruitment, medicines, staff training, supervisions, observation of staff attitudes, incidents and accidents and complaints. The outcome of these audits fed into an ongoing service improvement plan for action by senior staff. Records showed, and our observations confirmed, that actions identified in a recent audit had either been addressed, or were in the process of being completed. For example, Deprivation of Liberty Safeguards (DoLS) authorisations had been sought and notification sent to CQC where these had been authorised as part of the action plan. We also saw action had been taken in response to feedback from a local authority visit to the service which included putting a new business continuity plan in place, and ensuring observation charts for people were completed on a regular basis.

Staff maintained records detailing the care and support people received which were updated on a daily basis. We found improvement was required because records relating to the management of people's wounds had not always been updated in accordance with the specified frequency of dressing change. For example, one person's wound assessment plan identified the need to change a dressing every three days but there was a seven day gap between the most recent recorded change. We brought this attention to nursing staff who told us that the dressing had been changed during this period, but had not been recorded. The management team confirmed they would review all wound assessment records following our inspection to ensure they were up to date and accurate.

The home did not have a registered manager in post and had been managed by three different managers during the three months since registration under the current provider. We found improvement was required because this led to a lack of clarity when speaking to people about who they thought was responsible for the day to day management of the service. One staff member also raised concerns about the number of changes within the management team, telling us, "The staff are very caring, but we've had quite a few managers running the place in the last year so it has been difficult. Hopefully the new manager will stay and we will have some stability."

The current manager had started working at the home in June 2017. They were knowledgeable about the requirements of a registered manager and their responsibilities with regard to the Health and Social Care Act 2014. At the time of this inspection they were in the process of applying to the CQC to become the registered manager for the home.

Despite the changes in manager, people spoke positively about the management of the service. One person said, "I think there have been improvements [at the service] in every way. The place is like a palace compared to the other homes my daughter saw. I love the manager; they're really nice. They are very pleasant and easy to talk too, and more attentive." Another person told us, "I have no problems [with the management of the service]; you could get a thousand times worse."

Most staff also spoke positively about the leadership provided by senior staff and managers. One staff member told us, "I love working here. The staff and the residents are nice I get good support from the managers." Another member of staff said, "The managers are very supportive. I feel that I am part of a new team. I am really looking forward to making lots of improvements at the home." However one staff member commented that decisions made by the provider were not always properly explained, although it was too early to see if things would improve following the recent management changes.

Senior staff held daily meetings to discuss the management of the home and ensure they were aware of their day to day responsibilities at the service. Staff also confirmed that they attended handover meetings between shifts to ensure they were aware of any changes at the service or with the needs of the people they supported. The service had an out of hours on call system in operation that ensured that management support and advice was always available to staff when they needed it.

Senior staff told us they conducted regular open door surgeries for relatives and people to attend should they wish to discuss any aspects of the running of the home or concerns they may have. The manager explained that due to historic issues under the previous provider's registration, residents and relatives meetings had not been conducted in several months, but confirmed they had plans in place to arrange these shortly in order to facilitate wider discussions with people about the support they received.

People had been invited to submit their feedback about the service through a recent survey conducted by the provider, although not all of the people we spoke with could recall having been asked to do so. Records showed that the survey had only been recently conducted and senior staff confirmed the results were still to be analysed at the time of our inspection. Following our inspection the area manager sent us an updated version of the provider's service improvement plan which detailed action points in response to the survey results. These included continuing to recruit additional staff to support with activities, and action taken to ensure people were aware of the way in which they had been involved in the planning of their care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures had not always been effectively operated to ensure staff employed were of good character or had the right skills and experience.