HC-One Oval Limited

Bakers Court Care Home

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Bakers Court Care Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bakers Court Care Home can accommodate 78 older adults some of whom may have dementia or mental health difficulties in a purpose built three storey building. At the time of this inspection, 64 people were using the service.

This inspection took place on 5 and 9 November 2018. The inspection was unannounced. This was the first inspection since the service was registered under the provider HC-One Oval Limited in December 2017. During this inspection, we found two breaches of the regulations and the service is now Requires Improvement. We found there was not always enough staff to meet people's needs, care plans lacked detail and the provider's quality assurance systems did not identify the issues we picked up on at inspection.

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

Recruitment checks were carried out before new staff began working at the service. Staff knew how to report safeguarding concerns and whistleblowing. People had risk assessments carried out to mitigate the risks of harm they may face. Building and safety checks were carried out in line with building safety requirements and equipment was checked to ensure it was safe to use. There were systems in place to manage medicines safely. People were protected from the risks associated with the spread of infection. The provider used accidents and incidents to make improvements to the service.

People's needs were assessed before they began to use the service to ensure the right care could be provided. Staff were supported with regular supervisions to help them to carry out their role effectively. However, staff training was not always up to date in key areas. The provider had communication systems in place for staff to be updated on people's well-being and changes in care needs. People were supported to eat a nutritionally balanced diet and to maintain their health. However, the dining experience for people was not always positive. The provider and staff understood the requirements of the Mental Capacity Act (2005).

People and their relatives were involved in decisions about the care and thought staff were caring. Staff knew people well and understood their care needs. People were supported to maintain their independence and their privacy and dignity was promoted.
Staff were knowledgeable about equality and diversity.

Staff understood how to deliver personalised care. People were offered a variety of activities and their communication needs were met. Complaints and compliments were recorded and used to improve the service. The provider had a system to capture people's end of life care wishes.

People, relatives and staff spoke positively about the management of the service. The provider had a system in place to obtain feedback from people using the service, relatives and visitors. People, relatives and staff had regular meetings to be updated on important issues and service development. The provider worked in partnership with other agencies to improve the service provided.

We have made three recommendations about staff training, the dining experience and working within the requirements of the Mental Capacity Act (2005)..

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 consistently safe. There were not always enough staff to meet people's needs.

The provider followed a safe recruitment procedure.

There were systems in place to protect people from the risk of abuse.

People had individual risk assessments to mitigate the risks they may face.

Building and equipment safety checks were carried out.

Medicines were managed safely.

People were protected from the risks associated with the spread of infection.

The provider recorded accidents and incidents and used these to make improvements to the service.

Is the service effective?

Good

The service was effective. People had an assessment carried out of their care needs before they began to use the service.

Staff told us they found training useful. However, records showed not all staff were up to date in key training courses.

Staff were supported with regular supervisions to carry out their role effectively.

People were offered a choice of nutritious food and drink. However, we observed condiments were not always available to give people a positive dining experience.

There was effective joint working and communication within the staff team.

People were supported to access healthcare as needed.

Staff provided care in line with the requirements of the Mental Capacity Act (2005). However, the provider did not have a system in place for documenting consent to receive care and treatment.

Is the service caring?

Good

The service was caring. People and relatives gave positive feedback about the staff being caring.

Staff demonstrated they were caring through their interactions with people.

Staff knew about people and their care needs.

People and relatives were involved in making decisions about care.

Staff understood how to provide an equitable service.

People's independence, privacy and dignity were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not consistently detailed and were not always accurate.

Staff understood how to deliver a personalised care service.

People were offered a variety of activities.

Care plans included guidance for staff on the person's communication needs.

People received information in a format they could understand in line with the accessible information standard.

The provider kept a record of compliments and complaints.

The service had processes in place to meet people's end of life care wishes.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The provider carried

out regular quality audits but these did not identify the issues we highlighted during the inspection.

There was a registered manager in post.

People, relatives and staff gave positive feedback about the management.

The provider had a system in place to obtain feedback from people, relatives and visitors in order to identify areas for improvement.

The provider held regular meetings with people, relatives and staff to keep them updated on important issues and service development.

The service worked in partnership with other agencies in order to improve the service.

Bakers 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.

The inspection was prompted by concerns raised by members of the public and a whistleblower in relation to staffing levels and the quality of care provided.

This inspection took place on 5 and 9 November 2018 and was unannounced. The inspection team consisted of three inspectors, a specialist nurse advisor, a pharmacy inspector and two experts-by-experience. Both experts-by-experience had experience of caring for someone who uses this type of service.

Before the inspection, we looked at the evidence we already held about the service including notifications the provider had sent us. A notification is information about important events which the service is required to send us by law. We also spoke with the local authority to obtain their view about the service.

During the inspection we spoke with 14 staff which included the area director, registered manager, three nurses, six care workers, the chef, the maintenance person and one of the well-being co-ordinators (responsible for activities). We also spoke with 11 people who used the service and 11 relatives. We observed care and support provided in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed nine care records including risk assessments and care plans and reviewed six staff records including recruitment and supervision. We looked at records relating to how the service was managed including staff training, medicines, policies and procedures and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

People told us there were not enough staff on duty to meet their needs. One person told us, "I ring the bell and they walk away. I had to wait 2.5 hours. That happens any time after 9:30 pm." Another person said, "There is not enough staff in the daytime. I don't use the call bell I go to the nursing station if I need help." A third person told us, "They could do with more staff definitely."

Relatives told us they had concerns about the service being short staffed. One relative told us, "[Person] has woken up drenched. Sometimes her clothes are wet too. [Person] rings the buzzer at night and no one comes. They are not helpful at night. Sometimes, they come and say they will be back, but they take their time. Everything is done late. [Person] has had a few falls. No one saw her fall. They shouldn't leave her on her chair as she will try to get up." Two relatives said, "We appreciate staff are very busy. Don't think there is enough staff. If they could get more, it would be better." Another relative told us, "They are very short staffed. Since the new provider has taken over I have noticed that there is a delay."

Staff expressed concerns about staffing levels. One staff member told us, "Sometimes they are short on a weekend and during the week. Its stressful. I feel guilty when someone is calling out. I've mentioned to the nurse and manager several times. It could be my mother, my sister, my family." Another staff member said, "We have 19 residents and sometimes me alone. We should be four. When three we can [manage]. When two its impossible [to give good care]. At the end of the day who is going to suffer, the residents." A third staff member told us, "I don't think there's enough staff. People wanting to go toilet up to an hour. Not all the time but more often than not. I help with breakfast and lunch. I do it to help the carers."

One person we observed did not have the call bell in reach. This person told us if they needed assistance they shouted to get the attention of staff, but they did not always come. Throughout the inspection, we noted that people, including those at risk of falls, were frequently left unattended in the communal areas such as the dining rooms and lounges because staff on duty were busy supporting other people. We raised the issue with staffing levels with management who told us they would look at the deployment of staff.

Management confirmed with us the staffing levels they expected on each floor during the day and the night. Records showed the provider used agency staff to cover staff vacancies and absences. The registered manager told us they were in the process of recruiting to the vacant nurse and carer posts.

Staff rotas showed there were some days when a floor was staffed below the provider's expected levels. We noted the floor dedicated to people with dementia was expected to be staffed throughout the day by one nurse and four carers. However, there was one day where there was only one nurse and two carers on duty. On the floor dedicated to people who required assistance to manage their mental health, one nurse and three carers were expected to be on duty in the unit during the day. However, there were two days that showed a nurse and only two carers were on all day and two days that showed there was a nurse and just two carers on for the second part of the day. The ground floor where people required assistance with their physical health and mobility was expected to be staffed by two nurses and four carers on duty. However, we noted one day the four carers on duty reduced to three carers for the second part of the day.

The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. Staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had provided written references. New staff had undergone criminal record checks to confirm they were suitable to work with people and the provider had a system to obtain regular updates to check their continued suitability. This showed a safe recruitment procedure was in place.

The service had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK and ensures nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards.

The provider had safeguarding and whistleblowing policies which gave staff clear guidance on the actions to take if a person using the service was being abused. Staff confirmed they had received training in safeguarding adults. The management knew how to handle safeguarding concerns and had appropriately notified the local authority and CQC.

Staff explained to us the actions they would take if they suspected abuse. One staff member told us, "If I see something I call my staff nurse and report it to her and if I need to go to the manager make them aware of it. It's for me to see it and report it. I'd tell the family. I'd tell the nurse again. I'd tell the social worker." Another staff member said, "If I see something I take action immediately. If not doing anything I'd go to the manager. Go to the top and whistleblow. I'd raise a safeguarding." A third staff member told us, "When you see something like that you have to report to your line manager or the senior nurse on duty. [Whistleblowing is when] something is going on and you have told them, and they are not taking action on it, you can call head office or CQC."

People had risk assessments carried out to mitigate the risks of harm they may face. These included risk assessments for skin integrity, malnutrition, choking, bedrails and mobility. One person had a risk assessment for absconding which stated the person may play with the coded pad and push the door. The management plan stated, "Staff to ensure all exit doors on the unit are closed properly. Listen for the click sound as this is an indication the door is secured. Check on [person] regularly. When [person] is asking to go to Stratford staff to be aware of her whereabouts. [Person] must be accompanied by staff or family member if she is going out." This meant the provider took steps to mitigate the risks of harm to people.

Staff told us they had access to sufficient equipment to enable them to carry out their job safely. One staff member told us, "We do we have the hoists here [to] transfer people back to bed. They are in good working order." Another staff member said, "We have the hoist here and standing hoist downstairs and sliding sheet." A third staff member told us, "We always have enough equipment to use here." Records showed the maintenance person carried out regular monthly checks on equipment including the call bell system, bedrails, and wheelchairs. These were up to date with no issues identified.

Building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, the five-year electrical installation check was carried out on 2 June 2017, the annual gas safety check was carried out on 14 March 2018 and portable electrical appliances were tested on 24 July 2018. A fire risk assessment was carried out on 4 October 2018, the fire alarm system was serviced on 22 August 2018 and fire-fighting equipment was serviced on 17 September 2018. The maintenance person carried out monthly checks which included the fire alarm, fire-fighting equipment, emergency lighting and

window restrictors. These were up to date with no issues identified.

The provider had a comprehensive medicines policy which included clear guidelines for staff about medicine administration, ordering and receiving stocks of medicines and record keeping. Staff who administered medicines had the appropriate training and competency assessments to ensure medicines were given safely to people. Staff told us how medicines were obtained, and we saw that supplies were available to enable patients to have their medicines when they needed them.
As part of this inspection we looked at the medicine administration records for 39 people who used the service. People's medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately and records showed they were kept at the correct temperature, and so would be fit for use. Appropriate arrangements were in place for recording the administration of medicines and these records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. Quantities of medicines given when required were clearly recorded. The use of emollients and barrier creams was recorded on individual cream charts.

People who required 'pro re nata' (PRN) medicines had guidelines in place to inform staff about when these medicines should or should not be given. PRN medicines are those used as and when needed for specific situations. This meant staff had the information needed to make decisions as to when to give these medicines to ensure people were given them safely and consistently. The service kept a running stock balance for all medicines not in the monitored dosage system and the sample we checked were correct. The provider carried out daily, weekly and monthly checks to ensure the administration of medicines was being recorded correctly. This meant the provider had systems in place to ensure medicines were managed safely.

People were protected from the risks associated with the spread of infection. Staff told us they were provided with sufficient amounts of personal protective equipment such as gloves and aprons. We observed staff used and disposed of gloves and aprons appropriately. There were handwashing facilities available including hand soap and paper towels. The provider employed domestic staff to keep the premises clean.

The provider kept a record of accidents and incidents. The registered manager gave us examples of where lessons had been learnt at the service as the result of incidents. One example was a person's clothes had gone missing and could not be located. The registered manager explained to us a system was introduced whereby people's clothes were now labelled on admission or when relatives brought in new clothing items. This meant the provider used accidents and incidents to learn lessons and make improvements.

Good

Is the service effective?

Our findings

People and relatives told us staff had the skills to provide care. One person told us, "The staff are well trained." Another person said, "Yes, definitely the staff do have the skills to provide me with care." One relative told us, "Yes, I am confident [staff] have the skills to manage [person's] care." Two relatives said, "They [staff] do a very good job." Another relative told us, "As far as I see staff have the skills needed to provide the care."

People had a pre-admission assessment before they began to use the service which gave the reason for admission to the service and information about the person's needs in relation to medical conditions, communication, personal care and equipment required. When a person first began to use the service a more comprehensive assessment was carried out and a detailed care plan put together. Assessments included people's preference of gender of care staff and cultural needs. For example, one person's care records stated, "I need one staff for personal care, prefer a female." This meant people's needs were assessed and important information about the person could be captured to ensure the service could meet their needs.

Staff told us supervisions were useful. One staff member told us, "The nurse does it [supervision]. We talk about the [people using the service] and they give us a paper to sign. Another staff member said, "I do find [supervisions] useful. I speak about meal times. Our unit manager is really good." A third staff member told us, "Yes, supervisions are very good."

The provider had a supervision policy and records showed staff received supervision in line with this policy. Topics discussed in supervisions included, infection control, choking risks, communication, teamwork, food and fluid intake, record keeping and quality of care. This meant staff were supported with regular supervisions and discussions.

Staff confirmed they received regular training. Comments included, "[Training], it is useful. It freshens the brains you know", "I have been doing online training. It is useful. It refreshes your memory" and "The training [to date] from HC-One is all on computer. I do that many. I like my training it helps a lot."

New staff received induction training consisting of training in mandatory subjects and shadowing more experienced staff. New staff completed a six-month probation period before being confirmed in post.

The training matrix showed staff were offered a range of training including dignity awareness, care giving skills, fire safety, food safety. However, we noted there were key training courses which staff were not up to date with. For example, dementia training was offered as five parts and no staff had yet completed all five parts; 21% of staff had completed part one and 13% of staff had completed part two. Records showed and the registered manager told us they were aware of the low number of staff, 35% who were up to date with moving and handling training. The registered manager told us there was a plan in place as part of the home improvement plan to address this and moving and handling training was booked for 13 December 2018. They also said there was now an in-house trainer who would be delivering training to staff within the home and they aimed to be compliant with training by the end of December 2018. This meant not all staff had the

skills needed to deliver effective care.

We recommend the provider seek advice and guidance from a reputable source about supporting staff to carry out their role effectively.

People told us they were able to choose the food they ate. One person told us, "I do get a choice it is simple food, burgers and hot dogs." Another person said, "The food is lovely. It is always clean and nicely put on the plate." A third person told us, "The food is good." Relatives also gave positive feedback about the food. One relative told us, "The food it is excellent." Another relative said, "The food is all right. It is puréed, and they help feed [person]." A third relative told us, "The food is fine. [Person] gets enough, and has gained weight, as previously [person] was not eating well. They weigh [person] regularly."

Staff described how they offered choices to people. One staff member told us, "I've got a tray. I show [people who used the service] the tray. I explain to them and they point to it. If they don't like what's on the tray I offer alternative. [Person] likes curry and rice." Another staff member said, "Every time we are serving, we ask them what they would like to have. Sometimes we make two plates and show them." A third staff member told us, "We give them choices always. Some say I want orange drink or apple drink. Some people want rice and curry."

The kitchen was stocked with a good supply of fresh food, fruit and vegetables which was appropriately stored. The chef told us staff asked people for their food choices the evening before. The menu contained a choice of nutritious food and listed the calorie content of each meal. The chef was knowledgeable about people's dietary and cultural requirements. A relative told us there were a number of people from Caribbean descent living at the home and they could have their cultural food if they asked for it but it was not a regular item on the menu. We noted the menu did not contain listed vegetarian options although staff told us people could ask for a vegetarian meal if they wished. We discussed this with management who said they would consider adding a regular Caribbean meal option and a vegetarian option.

We observed lunch and saw staff showed people two plates of food to help them to choose what they wanted. Soft music was playing in the background. A choice of soft drinks was offered including mango juice. However, we noted there was a lack of condiments and menus on tables. We noted there were condiments in the small kitchens on each floor. One person who used the service told us there was no hot pepper sauce available at the home. We noted there was hot pepper sauce available in the kitchen. We raised this with the management who told us they would speak to staff about offering condiments and hot pepper sauce.

We recommend the provider seek advice and guidance from a reputable source about providing a positive dining experience for people using the service.

The provider had a system in place for staff finishing their shift to handover to staff taking over. Staff gave positive feedback about communication within the team. One staff member told us, "We work as a team. Everyone has their own department. Handover to night staff [about] residents one by one. We inform the manager if any changes. Everything is in the daily notes." Another staff member said, "The nurse tells us, or we read the file. We have to write a lot of charts. What they ate and drank. We record peoples weight every month and some weekly." A third staff member told us, "The Unit manager is always here to tell us. During handover in the morning or during the day they update and they inform us regularly." This meant staff received updates on people's well-being and changes in need.

People told us staff helped them to maintain their health. One person told us, "They do help maintain my

health. I get to see the doctor when I need too." Another person said, "They try to maintain my health, but I am getting old." Relatives confirmed staff supported people with their health needs. One relative told us, "Yes they do help to maintain [person's] health they keep me up to date about [person's] medication." Another relative said, "The optician came last week. They have a very good speech therapist who has done a swallowing care plan which is on the door."

Staff described how they supported people to maintain their health. One staff member told us, "We escort people to appointments and stay with them. If they tell us anything we document and tell the nurse." Another staff member said, "We encourage people to eat. We feed them if not well. [Encourage to] drink to stay hydrated. If I see someone not well, tell the nurse, so [they] can call the doctor." Records confirmed people had access to healthcare professionals as required and the outcome of appointments was recorded.

The building was laid out across three floors which were accessible by a lift. Rooms were personalised and contained people's choice of pictures and photographs. Bedroom doors were styled like street doors to houses and were different colours to help people to recognise their room. People had memory boxes outside their door which also helped them to recognise their room. The dementia unit contained a sensory garden alcove, a library alcove both with a bench for people to sit on. There was a wall with a display of different locks, a plug and a switch. The quiet lounge on this floor had been designed to be dementia friendly by the activities co-ordinator.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. At the time of the inspection there were seven people with legally authorised DoLS and 58 people awaiting a decision because they required a level of supervision that may amount to their liberty being deprived. Records showed assessments and decision-making processes had been followed correctly.

Staff demonstrated they were aware of MCA and DoLS. One staff member told us, "Some people can make decisions and some people we have to make the decision. Some people are very confused. DoLS is when doors are locked for safety as they [person using the service] can walk out." Another staff member said, "If the resident is forgetting anything, they can't leave the building, we have to stay with them. DoLS is why we have keypads and we are always here to keep them safe."

People confirmed that staff asked for their consent before delivering care. Staff were knowledgeable about the need to obtain verbal consent. One staff member told us, "You can ask if you are going to assist them. If you are dressing them you have to let them choose what they want. You have to give the person choice." Another staff member said, "In every decision whatever we are doing for them we have to take consent and permission."

However, we noted the provider did not have a system in place for documenting consent to receiving care

and treatment. We recommend the provider seek advice and guidance from a reputable source about working within the requirements of the MCA.

Good

Is the service caring?

Our findings

People told us staff were caring. One person said, "They treat me like a king." Another person told us, "I love it here, yes definitely, the staff couldn't be any nicer. They are caring. The staff do listen. They are very kind I could not wish for better." A third person said, "I think so, they [staff] are very pleasant." Relatives gave positive feedback about the staff. One relative told us, "Yes the staff are kind and caring. They are all fine. Staff do a good job." Two relatives told us they were happy with the care and, "They [staff] do a very good job." Another relative said, "Staff are nice, not a problem and always willing to help. It is good I get on well with them [staff]."

Staff explained how they developed positive relationships with people from when they first began to use the service. One staff member told us, "When they [people using the service] come, we talk to them [and] find out their name. If they can't talk we read their folder. If [they have] family we speak with them." Another staff member said, "We spend the whole day with them. We are talking friendly with them and we are giving them choices as well. I get to know them by going through the paperwork with them and we get to know their likes and dislikes." A third staff member told us, "If a new resident comes in, we have a handover, they will say everything to us. You can introduce yourself to them. You can ask them questions. When we go home we think about them."

We saw examples of positive caring interactions between staff and people who used the service. One example was the activities co-ordinator who spoke with a person using their preferred form of address and although they were non-verbal, this staff member spoke to them in a soft voice and gave them eye contact.

The provider had a keyworker system in place where each person using the service had a named nurse and a named carer. A keyworker is a staff member who is responsible for overseeing the care a person received and liaising with other professionals or representatives involved in a person's life.

The registered manager explained how people and their relatives were involved in decisions about the care provided. They told us, "It starts from the pre-admission. We have to find out their needs and their likes and their dislikes. When they [person who used the service] come in the home, we arrange to have meetings with the resident and relatives. Then every month we do a care plan review and we contact the next of kin to discuss the care and if there is a change in needs we discuss that." Relatives confirmed this was the case. One relative said, "Oh yes I am involved in decision making they discuss his care with me." People's care plans documented communication with relatives.

The service had a 'resident of the day' system in place where each day a person was made to feel special and had their care plan reviewed. On this day, the person could choose to have a special meal and have an activity of their choice.

Staff told us how people and relatives were involved in their care decisions. One staff member said, "We get them involved when they need clothes, toiletries. One likes a male [staff] so just got a male staff started recently. Sometimes I speak in my language to a resident if they need something. We don't normally but I'd

do it to support the resident." Another staff member told us, "We give preference of staff. Its written in the book what they want as staff preference. Night have male carers." A third staff member said, "If any changes, will let relative know. Hospital appointments we tell the relative."

The provider had an equality and diversity policy which gave guidance to staff about providing an equitable service. Records showed staff were offered equality and diversity training. The registered manager told us, "We look at each individual as an individual. We have residents who eat cultural foods we do cater for them. We have a lot of residents whose language is not English so I have to make sure I have staff who can speak their language. We tend not to discriminate against people, we give them their choices and treat them as individuals. It will be mentioned in the pre-admission what their religious needs are and if they have any special wishes that will be written down."

Staff knew how to treat people equally. One staff member told us, "During the day we give them same care. Everyone is treated equally I think. We can't change one person and leave the other person. I think people here are treated very well." Another staff member said, "We wash and dress each person. We wouldn't leave a person wet. If we [are] short of staff we can't treat people equally." A third staff member told us, "By talking to them. The residents will complain if they are not happy about something. We have to be nice and helpful for all the residents."

The registered manager and staff explained how they would support people who identified as being lesbian, gay, bisexual or transgender (LGBT). One staff member told us, ""Support them the same way, don't treat different from others." Another staff member said, "You have to treat the person as you are supposed to. This is a care home and we will treat [people using the service] as they want." A third staff member told us, "I'd treat them nice. Wouldn't treat them any different. Wouldn't say nothing to them it's their choices. Treat everyone same. All got equal rights." The registered manager said, "We will support their wishes and decisions just like anyone else. We will treat them equally. There is a training online for equality and diversity. We talk about it in staff supervisions."

People's privacy and dignity was promoted. People confirmed their privacy was respected. The provider had a policy which gave clear guidance to staff about promoting people's privacy and dignity. We observed staff knocked on doors before entering people's bedrooms or bathrooms. One staff member told us, "We have to knock the door before we enter. We have to close the door and curtain before we assist. We have to greet the person before we start." Another staff member said, "For example, knock before you enter, when go in greet them. When washing, cover area, make sure curtain is closed." A third staff member told us, "We always shut the door and close the curtains and we don't allow anyone to come in if we are changing or toileting. We keep [personal information] in confidence, we don't tell the other residents"

The service supported people to maintain their independence. One person told us, "I can feed myself, they cut up my food for me." Staff described how they promoted people's independence. One staff member told us, "We help them. If they can wash their face, give them flannel. They may say 'I want to do it' and we encourage them to do it. It's better if they can do something for themselves. If they can't we help them." Another staff member said, "To give them more choices, they can walk and come to us if they want something. Some residents will come to the kitchen and ask." A third staff member told us, "If person wants to get changed, I ask [them] to try. I say 'you can do it', for example, putting on a jumper."

Requires Improvement

Is the service responsive?

Our findings

Staff described how they delivered personalised care to people. One staff member told us, "[Person's] got particular things she likes. [Person] has oils for legs. We always ask what they would like." Another staff member said, "To involve the resident in their care, all the decisions we are taking. We should respect them and do everything according to their beliefs and their choices." A third staff member told us, "You have to give the care [the person] wants."

People had a summary of their care needs at the front of their file. Care records were personalised containing people's life history and preferences. For example, one person's care plan included, "[Person] prefers female to assist her with personal care. Staff to explain the task they want to do and gain consent. [Person] doesn't like to be forced." Staff were able to describe in detail people's individual care needs. However, we noted care plans did not contain this level of detail, were not always accurate and contained gaps. For example, one person had a variety of wound care plans and charts which stated the frequency of wound dressing as, "When required" rather than specifying the frequency. The care record for another person who used a catheter did not contain a catheter care plan to give clear guidance to staff about the positioning and flushing regime of the catheter. Fluid charts for people indicated how much fluid was drunk but did not contain the target daily amount for the person or the total amount consumed each day. Another person's care plan stated to inform family if skin integrity deteriorated. However, this person did not have any family to be notified

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People described how they fulfilled their time. One person told us, "I read a lot." Another person said, "There is enough to do. I talk to people. I play bingo. I go to the activities with [activities co-ordinator]. I don't ever get unhappy or feel lonely." A relative told us, "When the housekeeper said that there was a singer, she took [family member] into the lounge as she thought he would enjoy it."

There were currently two well-being co-ordinators employed at the service and the provider was recruiting a third person. These staff members also had the responsibility for providing activities to people using the service. The activities office contained various items for delivering activities. Records showed there was a wide range of activities offered. Each unit had the home's weekly and monthly activities displayed on a board. Activities offered included skittles, bingo, hairdressing, nail care, massage therapy, sports on the big screen, exercises, sherry and canapés, afternoon tea and visiting entertainers. The planner included time allocated for visiting people in their rooms for one to one activities which could include current affairs, massage therapy, music therapy and reading poems.

People had an activity record which was updated by the activity co-ordinators. One person who enjoyed walking around and dancing told us that they enjoyed doing this and we saw this was recorded in their daily activity record. Another person liked listening to music and current affairs and this was documented.

Throughout the inspection, we observed different activities taking place. There was an art session facilitated by three staff members which people were seen to enjoy which was evident by willingness to participate in drawing and painting poppies for Remembrance Day. Other people were observed having their hair styled in the hairdressing salon. Another activity involved a sing song and light sessions and the atmosphere was fun and lively. We observed some people sang solo and many were dancing with staff. Staff interacted enthusiastically with people throwing balloons and soft balls and some people were playing musical instruments. It was clear from the atmosphere, the number of people attending and expressions on people's faces that this session was enjoyed by everybody involved.

People's cultural and religious needs were considered when activities were planned. For example, there was a weekly church service for all faiths and celebrations for Diwali in November included a visit from representatives from a local temple with lights and cakes.

The environment was adapted to suit the needs of the people using the service. For example, we saw that a room where people took part in activities included a made-up cooker and facilities for people to engage in. The activity co-ordinator told us that this had been specially built for people who enjoyed taking part in cooking. This room also contained a special sensory area with different themes where people were able to touch different textures.

We asked the registered manager what they had done to implement the Accessible Information Standard (AIS). The AIS requires providers to evidence that they record, flag and meet the accessible communication needs of people using the service. The registered manager explained how they would meet the communication needs for people with dementia, a sight impairment or a hearing impairment. They told us, "With people with dementia, sometimes you show them pictures to help them understand. I could do referrals for glasses or magnifying glasses or I can get [information] in large print. I am sure we could get [information] translated into braille. I will check if [person] needs a hearing aid. I can give them a notepad and I can write [information] down for them."

People's communication needs were detailed in their care plans. One person's communication care plan stated, "[Person] can communicate well in English. She can express her needs. [Person] is able to use call bell. She has cognitive impairment and slightly deaf. [Person] has no problem with vision. She has hearing impairment. When staff talk to her, they should be loud and clear. [Person] able to make choices from two options." This meant staff were able to respond to people's communication needs

People and relatives knew how to make a complaint if they were not happy with the care provided. One person told us, "I have no complaints. The carers are too nice and we are lucky to have them." Another person said, "My [relative] has complained they have left me in bed for too long." A relative told us, "I have never complained." Another relative said, "Yes we made a formal complaint today, it is first time we have done that. They are starting to investigate it."

Staff were knowledgeable about how to handle complaints. One staff member told us, "We always tell them 'Okay, I will let the nurse, or let the manager know and they will come and listen to you and your complaints.' [The nurse] comes, and she takes time and will sit with them." Another staff member said, "Make them [people using the service] calm down, listen to them and let the manager know." A third staff member told us, "You have to allow the person [to complain]. Sometimes they might ask to speak to the nurse or to speak to the manager."

The provider recorded complaints and actions taken in order to make improvements in the service. There

was a complaints policy which gave clear guidance to staff about the actions to take if they received a complaint. We reviewed the record of complaints and saw five complaints were recorded since January 2018 and these were dealt with appropriately in line with the policy. For example, a relative had complained the person's bedroom was cold. The actions taken included the person being offered a change of room, offered more blankets and a low surface heater was purchased for use.

The service kept a record of compliments. One written compliment stated, "This home is second to none. The staff, including activities, nurses, carers, admin, housekeeping and kitchen treat [person] like family. [Person] is very happy which is a load off my mind. They are all pleasant, helpful and kind to me." Another written compliment stated, "I found the staff very good in everything they do. I feel this is one of the best homes I have visited. I would totally recommend this home."

At the time of this inspection there were two people receiving end of life care. People's end of life care wishes were documented in an advanced care plan. Records showed where appropriate, people had a 'Do Not Attempt Cardiopulmonary Resuscitation' agreement in place. These were signed by the GP and included consultation with relevant family members.

Staff knew how to deliver care sensitively when people were at the end of their life. One staff member told us, "Had end of life training. We don't have anyone on end of life [on this floor]. Nurse in charge would help us." Another staff member said, "You have to encourage them to drink more or to eat a bit more and you have to smile with them and talk to them." A third staff member told us, "When we know, and the resident knows that this is their end of life they lose their hopes, and they will just want to sit and relax, and want to sleep. We do go to them, we feed them, we change them, and we give them a comfortable position. We give the time to the family and the resident."

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. There was a registered manager at the service. The provider carried out regular quality audits. However, the issues we highlighted at inspection were either not identified or acted upon in a timely manner through the provider's quality assurance systems regarding staffing levels, staff training, the dining experience, and record-keeping.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and deputy manager carried out a variety of quality audits. The provider had a timetable of what needed to be audited each month by management. For example, monthly checks were carried out on the number of pressure wounds, weight management and the number of falls. Records showed the deputy manager had carried out an unannounced out-of-hours visit on 19 October 2018 and the registered manager had carried out a similar visit on 27 October 2018. We noted that no concerns were identified at either of these visits. We reviewed the care plan audits carried out by the registered manager and the deputy manager in October 2018. Actions identified for one person was for their life story to be completed, their property to be recorded and for the family to sign consent for bed rails. We noted these were actioned and signed off as completed by 7 November 2018.

The area director visited the home twice a month and completed a full home visit report every two months. We reviewed the audit carried out on 30 August 2018 and noted staff training was identified as an issue and added to the home improvement plan. The action stated, "Work with learning and development team to ensure that all colleagues complete their compliance and required courses in a timely manner to ensure knowledge and skills are kept up-to-date, once allocated." We also noted the issues we identified with care plans had been identified during this audit but at the time of this inspection sufficient action had not been taken to rectify this.

People and relatives spoke positively about the management of the service. One person told us, "I always talk to the manager." Another person said, "There are five managers here. Yes, I can talk to the manager she is a nice person." A third person told us, "Oh yes, the manager, she is lovely she is very good at her job. I am very happy with how the service is run you could not wish for any better." A relative told us, "Yes the service is well managed. I would approach the nurse on the desk." Another relative said, "The manager is lovely. Staff are nice not a problem and always willing to help." A third relative told us, "The manager is very good. I like her."

Staff gave positive feedback about the registered manager and the support they received. One staff member told us, "When you say something, [registered manager] listens. She told us we are recruiting. I get good praise from the manager. When [registered manager] comes back from a meeting we ask her 'How are we getting on?'" Another staff member said, "[Registered manager] listens to you. She talks to you. She told us she's taking on more staff." A third staff member told us, "Service is well run. [Registered manager] is a very, very good leader."

The provider had an ongoing system of obtaining feedback from people and their relatives. People using the service, relatives and visitors were able to use a screen in the reception area to complete the feedback survey. We saw the screen feedback survey asked how satisfied respondents were with safety, environment and facilities within the home, the kindness of staff, mealtimes and activities. As it was less than a year since the provider took over the service the information captured through this screen had not yet been evaluated and analysed. This meant the provider had a system in place to capture feedback about the quality of the service and make improvements.

The provider held meetings for people using the service and relatives. We reviewed the minutes of the meetings held in April and September 2018. Topics discussed included staffing levels, fire alarm testing, meal service and condiments, activities and personal care. We noted the registered manager documented actions arising from these meetings and when the actions were completed.

The provider had a system of holding regular meetings with staff. The registered manager told us that previously separate meetings were held on each unit but a new system was introduced where meetings were held for all staff. We reviewed the minutes for meetings held in August and October 2018. Topics discussed included meal service, offering choices, signing in books, training, completion of supplementary charts, dignity and respect, feedback station in reception and home manager surgery with staff.

The registered manager had a daily meeting with the deputy manager and unit managers. These meetings were used to update everyone on the well-being of people who used the service and activities and events occurring on the day. Prior to these meetings unit managers carried out a daily walk around of their unit and used the information collected to report to the daily meeting with the registered manager. The registered manager walked around the premises twice daily to check on staff performance and various aspects of care including the general care of people, infection control, the premises and the dining experience.

The registered manager gave examples of working in partnership with other agencies in order to improve the service. They said, "We do work very closely with the local authority and the social workers. We get a lot of support. I go to the providers forums; we normally have them every quarter. They even ask if there is any problems we are facing."

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 17 HSCA RA Regulations 2014 Good governance (2) (a) The provider did not assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (2) (b) The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) The provider did not ensure they employed sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet the requirements of this regulation.