

Bupa Care Homes (CFChomes) Limited

Heathgrove Lodge Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

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

Heathgrove Lodge is a 'care home'. The accommodation is purpose-built with passenger lift access to all four floors. People in this care home receive accommodation along with nursing and 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.

The service had a registered manager, which 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.

The service is registered to provide accommodation and personal care for up to 36 people, although the registered manager told us the maximum practical occupancy is 33. There were 27 people using the service at the start of this inspection. The service specialises in dementia care and is operated by a national care provider.

This was an unannounced comprehensive inspection, to make sure the service was providing care that is safe, caring, effective, responsive to people's needs, and well-led.

At our last inspection of this service, in April 2017, we found three breaches of legal requirements. These were in respect of receiving and acting on complaints, fit and proper persons employed, and duty of candour. The service was rated 'Requires Improvement.' The provider completed an action plan to show what they would do and by when to improve the rating of key questions of 'Is it Safe?', 'Is it Responsive?' and 'Is it Well-Led?' to at least 'Good.'

At this inspection, we found the necessary improvements had been made to address the previous regulatory breaches. However, we also found there were not enough call-bell pagers available for all staff to be aware of anyone's call-bell being activated, and so we found call-bells were not always promptly attended to. We found that up-to-date information in people's care plans was not always easily accessible in support of ensuring staff provided people with an individualised service. The service was also not making sure any conditions on Deprivation of Liberty Safeguard (DoLS) authorisations were being met.

There were many auditing processes at the service that fed into an overall improvement plan that was kept under review. However, these processes had not identified and addressed the care delivery concerns we identified, which demonstrated weaknesses in the provider's governance framework.

Some people praised the service and told us they would recommend it, and no-one said they would not. Most relatives and representatives agreed.

Community professionals praised the service for working well with them in support of meeting people's

needs. People were supported to have access to healthcare services and receive ongoing healthcare input, for example, in relation to skin care or nutritional concerns. People were safely supported to eat and drink enough and maintain a balanced diet.

There were a number of systems in place to monitor and improve on the way staff interacted with people. This helped ensure people were treated respectfully.

The service assessed people's needs so that care and support was delivered in line with standards to achieve effective outcomes. There was good oversight of people's significant and developing needs.

The service assessed and managed risks to people, to balance their safety with their freedom. This included for individual needs and in terms of health and safety across the premises. Improvements were being made to help ensure the adaptation, design and decoration of premises supported people's individual needs to be met, as the design of the building was not ideal.

People's medicines were managed and administered safely, so that people received their medicines as prescribed.

The service provided people with daily communal activities that attempted to reflect their interests.

The service's systems, processes and practices helped to safeguard people from abuse. This included through stronger staff recruitment systems, to ensure only suitable staff started working at the service.

Minimum staffing levels were identified and maintained based on people's needs. There was ongoing recruitment of staff to address vacancies that were causing a degree of agency staff use. The service made sure employed staff had the skills, knowledge and experience to deliver effective care and support.

People and their representatives were supported to express their views and be actively involved in making decisions about their care and support. The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service worked in partnership with other agencies to develop care provision. There was active engagement with the local authority in particular, in support of improving care and treatment outcomes for people.

The service was aiming to promote a positive and inclusive culture that achieved good outcomes for people. There was ongoing work to continue to improve the calibre of the staff team and the working culture at the service.

The service's rating from this current inspection remains 'Requires Improvement', the third consecutive time it has received that rating based on a comprehensive inspection. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. It assessed and managed risks to people, to balance their safety with their freedom. This included for individual needs and in terms of health and safety across the premises.

People's medicines were managed and administered safely, so that people received their medicines as prescribed.

The service's systems, processes and practices helped to safeguard people from abuse. This included through stronger systems to ensure recruitment processes were ensuring only suitable staff started working at the service.

Minimum staffing levels were identified and maintained based on people's needs. There was ongoing recruitment of staff to address vacancies that were causing a degree of agency staff use.

There were systems and practices for preventing and controlling infection.

Good 

Is the service effective?

The service was effective. It assessed people's needs so that care and support was delivered in line with standards to achieve effective outcomes.

People were supported to have access to healthcare services and receive ongoing healthcare input within the service and through liaison with community healthcare professionals.

People were safely supported to eat and drink enough and maintain a balanced diet.

The service made sure employed staff had the skills, knowledge and experience to deliver effective care and support.

The service was working towards the principles of the Mental Capacity Act 2005.

Improvements were being made to help ensure the adaptation,

Good 

design and decoration of premises supported people's individual needs to be met.

Is the service caring?

Good ●

The service was caring. There was positive feedback about the approach of staff.

There were several systems in place to monitor and improve on the way staff interacted with people. This helped ensure people were treated respectfully.

People and their representatives were supported to express their views and be actively involved in making decisions about their care and support.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive. There were not enough call-bell pagers available for all staff to be aware of any call-bell being activated, and so we found call-bells were not always promptly attended to.

People's care plans provided a lot of detail on their needs, preferences and routines in support of providing person-centred care. However, up-to-date information in care plans was not always easily accessible in support of ensuring staff provided people with an individualised service.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service provided people with daily communal activities that attempted to reflect their interests.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led. Auditing processes had not identified and addressed care delivery concerns we identified, which demonstrated weaknesses in the provider's governance framework.

The service was aiming to promote a positive and inclusive culture that achieved good outcomes for people. There was ongoing work to continue to improve the calibre of the staff team and the working culture at the service.

The service worked in partnership with other agencies to develop care provision. There was active engagement with the local

authority in particular, in support of improving care and treatment outcomes for people.

Heathgrove Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 9 and 18 May 2018. It was undertaken by one inspector, a specialist professional advisor nurse, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted the local authority and various community healthcare professionals who have a role at the service, for their views on the service. We received four replies.

There were 27 people using the service at the start of our inspection visits. During the inspection we talked with seven people living at the service and nine of their relatives and representatives. We spoke with four care staff, three nursing staff, the maintenance worker, the deputy manager, the registered manager and the regional director.

During our visits, we looked at selected areas of the premises including some people's rooms, and we observed the care and support people received in communal areas including at meals. We looked at the

care plans and records of 11 people using the service, the personnel files of four staff, and some management records such as for health and safety, accidents and incidents, complaints, and staff rosters. We also requested some further specific information from the registered manager about the management of the service in-between and after our visits.

Is the service safe?

Our findings

At our last inspection, we found staff recruitment processes were not robust enough to ensure that only suitable staff provided care and treatment to people. This meant the provider was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made which addressed the breach as the provider was ensuring only suitable staff started working at the service. The recruitment files of new staff showed that appropriate checks were completed before they started working with people using the service. This included checks of identity, right to work, and criminal records. Three written references were sought, including from the applicant's previous employments in care. Gaps in employment histories were explored including through the applicant making a specific declaration.

We saw oversight information from the provider's recruitment team updating on when new staff could start and what recruitment checks had been made or were still outstanding. It was clear that there was ongoing recruitment to fill the employment vacancies at the service.

The service was ensuring sufficient numbers of suitable staff to support people to stay safe and meet their needs, but there was some reliance on agency staff for this. People and their relatives and representatives generally felt there were enough staff. One person said, "The staff are busy, but they do stop and talk when they can." Another person, who tended to stay in their room, told us of lots of staff popping in to see them. People's visitors told us staff "always seem to be there" and "There's lots of staff."

Our observations found there to be enough staff to meet people's needs, although staff did appear at times to be busy and lacking time to interact proactively with people. The management team told us minimum staffing levels was two nurses and six care staff during the day, and half that at night, along with staff working in other roles.

A dependency tool was used at least monthly to review each person's needs and calculate the overall number of staff needed. Our knowledge of people's needs from our visits indicated the tool was accurately used. The minimum staffing levels slightly exceeded the hours required by the tool. We were therefore satisfied that enough staff were deployed to meet people's needs.

We checked the staffing rosters and other records for the previous month. These showed that the minimum staffing levels were adhered to. However, 29% of the staff provided were agency staff, equivalent to one out of every four care and nursing staff working. The management team explained recent challenges to this service for deploying nursing staff due to staff sickness. They acknowledged a high turnover of care staff, and could show us ongoing recruitment processes were yielding new staff starting work.

The registered manager explained how only agency staff who knew the provider's services were hired, which helped with promptly fitting into the service and supporting people well. An agency nurse confirmed this. We saw that the department involved in the hiring process ensured summaries of training and recruitment

checks were sent through for each agency staff member. There were also systems for ensuring effective handovers of pertinent information for incoming staff including agency staff. The service was therefore taking sufficient steps to ensure enough capable staff were working in support of meeting people's needs and keeping them safe.

The service assessed and managed risks to people to balance their safety with their freedom. People told us they felt safe using the service. Their relatives and representatives agreed, saying for example, "It is a safe environment." There were a variety of risk assessments and subsequent care plans in place to recognize people who may need further support to keep them safe. For example, some people had been identified as being at risk of choking. There was individual guidance for staff to follow on how to keep them safe, which staff could inform us of. The registered manager told us of acquiring training from a community professional on people's specific choking needs.

Records informed us of falls being well-managed at the service. People had bed-rails in place where assessed as the least-restrictive safety option, and we saw regular checks of these recorded. We were also shown the lowered bed and crash-mattress for one person where the registered manager explained they were at too much risk from bed-rails.

Staff feedback and the service's training records showed staff received face-to-face practical training on the safety topics of emergency first aid, moving and handling, and fire safety. The registered manager told us the last two took place in the service, to reflect the unusual layout of the building. The fire training was new and almost complete, after which some fire drills would take place to help ensure all staff understood the training.

There were systems in place to ensure designated staff at the service undertook safety checks regularly. This included for fire safety matters, equipment safety such as wheelchairs and water temperatures, and room safety such as bed-rails and window restrictors. There were professional checks certificates in place where appropriate, such as for mobile hoists, electrical wiring and fire safety. Where actions were required, these had been signed off as completed.

The service's systems, processes and practices safeguarded people from abuse. There were appropriate systems in place to ensure thorough investigations and appropriate actions took place. Our discussions with staff showed they were trained in safeguarding. They told us ways of keeping people safe from avoidable harm, examples of potential abuse, and what procedures they had to follow if they suspected any abuse. Staff interview records included questions on safeguarding and whistle-blowing. These matters were also discussed within the provider's induction process that all new staff attended.

The registered manager told us of providing clear guidance in supervision meetings and sending out reminders to staff when poor practices came to light during safeguarding investigations. Staff meeting minutes also showed discussions on what was learnt and expected standards arising from safeguarding investigations.

The service ensured the proper and safe use of medicines. People told us their medicines were supervised and well-managed. We saw people receiving their medicines in a calm and unrushed manner, and with the support they required. The nurse patiently explained what the medicine was for and how it would help.

Medicines were administered by staff trained to do so. Medicine administration records (MAR) were accurately and fully completed, showing when people received their medicines. There were guidance forms outlining medication usage for when anyone was prescribed a medicine needed only when required, such

as for pain management.

Medicines were securely stored in the service, both in a clinical room and within trolleys during medicines rounds. Only appropriately trained staff had access. Controlled drugs were appropriately administered and recorded, and there were daily checks of stock to ensure it was all accounted for.

The service had systems to protect people by the prevention and control of infection. People told us the service was kept clean. One person said, "This place is clean; have you noticed? My room is very clean." Another person's visitor told us, "It's very clean, it's like a hotel."

We saw staff using protective equipment such as disposable gloves and aprons. They were aware of which bags to use for infection control. We saw staff carrying such waste using appropriate infection control procedures. Secure locks had been added to the three sluice rooms doors where disposable waste was stored pending permanent removal from the service. Two of these rooms had been refurbished to make them more easily cleanable and address infection control risks. The registered manager told us this would happen to the third room soon.

There had been a professional check against the development of Legionella within the service's water systems, with required actions having been signed off as completed. There was also a quarterly infection control audit of the service that identified the service as 85% compliant, equivalent to 'good enough' overall according to the provider's guidelines.

The service learnt lessons and made improvements when things went wrong. The registered manager told us of much work to eradicate poor practices at the service. She explained that staff historically did not report concerns at this service, but that safeguarding investigations were now showing that allegations were taken seriously. Consequently, learning from investigations was shared amongst the staff team, as per staff meeting minutes seen, and disciplinary processes were followed where appropriate. Similarly, care records were regularly checked on to ensure they were both up-to-date and not written in advance.

Is the service effective?

Our findings

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. People praised the general approach of staff. Their representatives told us staff were capable, with comments such as, "They do their jobs well" and "Staff know what they're doing."

Staff told us they had received relevant training to do the job. One said, "The support provided for me personally is good and has improved in a number of ways especially with 'BUPA-learn' where I have access to do mandatory trainings online."

Records and feedback from staff and the registered manager informed us new staff received four days of induction training from the provider. Comprehensive workbooks were seen that tested knowledge during this process. New staff then shadowed established staff at the service for a week, to help understand people's needs and provide effective care.

The service had clear systems by which to monitor that the training of employed staff was up-to-date. Across the service, this was being maintained well. It was possible to see which staff had completed which training at a glance. Along with standard safety courses, the training included for dementia, bed-rail use, and pressure ulcer care. Records showed practical training occurred for moving and handling including hoisting, and for fire safety. We were also shown records of staff receiving knowledge checks on a variety of topics.

Oversight records showed care and nursing staff ordinarily received developmental supervision on a quarterly basis. We saw letters indicating all staff were to have an appraisal meeting in June 2018, to consider their work across the last year and plan objectives for the following year.

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. For example, care plans had been put in place for someone who recently moved into the service, within the provider's policy expectation of three days. This followed the service meeting the person in advance of moving in, to assess their needs and preferences. Their clinical needs were recorded within the service's nearest weekly clinical meeting minutes.

Two people were recently discharged back to the service from hospital. The service's handover records reminded staff to check on a specific matter daily for one of them in support of ongoing healthcare. Records in the other person's room showed their nutritional support needs had been promptly updated. An agency nurse we spoke with was aware of these changes.

The service kept good oversight of people's significant and developing needs. We saw daily handover records by which to ensure incoming staff were informed of latest developments on each person. The registered manager told us there was a system of visiting each person during the handover, to help ensure their needs had been attended to and were communicated fully. Staff confirmed this as useful. There continued to be weekly clinical meetings to review people's significant treatment needs. The registered manager had also implemented a system in her office that summarised those needs in an easily accessible

way.

The whole service worked in co-operation with other organisations to deliver effective care and support. Community healthcare professionals provided positive feedback about how the service worked with them. One told us of responsive and communicative staff who worked in co-operation with them to attend to people's healthcare needs. Staff told us of the various local support teams that they worked with, which helped reduce hospital admissions. One person was happy that staff helped them with attending hospital appointments.

The service supported people to live healthier lives, have access to healthcare services and receive ongoing healthcare support. Records showed the service communicated effectively with community healthcare professionals such as GPs, dietitians and opticians in support of people's health needs.

The registered manager told us of good attention to people's skin integrity needs. Records showed evidence of a necrotic pressure wound healing on one person's foot. There was good involvement of a tissue viability nurse to help with this. Care staff told us of receiving training on pressure ulcer and wound care management, which helped ensure better skincare for people.

The service supported people to eat and drink enough and maintain a balanced diet. People provided positive feedback about the food and drink. One person said, "The food is good." Another person told us, "I didn't used to eat everything but now I do, the food is very nice." A third was happy that food was pleasantly served to them in their room and was "cut-up nicely." They said there was enough to eat and drink. A fourth person confirmed they got enough to drink in their room. A visiting relative praised the service for finding food their family member would eat.

We saw lunch, in the service's small dining area next to the kitchen, to be unrushed and appealing to people. The menu was displayed on the notice board of the lounge, at the entrance of the dining hall and on the dining tables. People were offered choices of drink, food and seating. Those who needed straws had them to support with drinking. There was kind and open engagement from the chef. The food looked appetising and well-presented, and people ate well. Many people had soft or pureed food. It was served in its component parts, to help distinguish foods visually and in terms of taste.

During the afternoon we saw hot drinks, smoothies, and home-made biscuits and walnut cake being served. Regular hot and cold drinks were served throughout the day. Water or squash was also provided in people's rooms. We saw fitted fans in use in most people's rooms, to help cool temperatures when needed. Training records showed all staff had completed training on nutrition and hydration. People's weights were kept under review, and referrals were made for community dietitian support where needed. There was clear guidance on who needed what, such as fortified or thickened drinks, to help make sure people got the safe and effective support they needed with food and drink.

There was ongoing work to make sure the adaptation, design and decoration of the premises supported people's individual needs to be met. This was because of the unique design of the building across four levels with thin corridors that mostly formed a loop. This made it harder to see and hear who was around. A relative told us, "The staff do their best within the constraints of an outdated building."

We saw that the three wet-rooms for showering in were also used to store some equipment as there was nowhere else easily available. Some refurbishing work was taking place to make the rooms safer to use.

There were now key-pad accessible doors at the top of staircases. The registered manager explained the risk

of falling down the stairs outweighed people's freedom of movement given the particular layout of the premises. The registered manager told us the service was therefore tending to avoid accepting new referrals for people who used equipment such as walking frames to mobilise. This would be reviewed once appropriate safety gates were fitted directly to stairs.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service was working towards the principles of the MCA. There was an oversight record of the DoLS status of each person, which showed dates when an application had been submitted if necessary, whether or not granted, and further reapplications for when granted applications expired. This helped the service keep up-to-date. However, the record did not show what conditions granted applications were subject to, and whether the conditions were being followed. The registered manager agreed to consider adding this.

Training records showed all staff had completed training on the MCA and DoLS. Staff confirmed this, and nurses could explain how they applied the MCA, including the assessment and the capacity processes. The registered manager told us of acquiring recent training on MCA principles from representatives of the local authority, to help ensure the service was following their expectations and to make improvements where needed. Information from a representative of the local authority confirmed this was occurring.

We saw occasions where staff provided support to people without first gaining consent. This was for providing people with drinks and pushing their wheelchairs, which we saw taking place without the staff member first asking if the person if they wanted support to drink or move. We subsequently saw records showing action taken to address this practice.

A staff member told us that someone used to refuse personal care for various reasons, but over time they had developed trust in some staff and so if the need was explained, the person would accept support. The registered manager told us of having to explain to a relative that the service could not force their family member to do things against their will despite it appearing to be in the person's best interests. This was because the person had capacity to make the decision for themselves. However, they also recognised which staff were better at encouraging the person.

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion. People and their representatives praised how staff treated people. One person told us, "I'm very happy with staff, they're terribly nice." Another person said, "They are very kind to me here." A third person added, "They're very kind people who help me." Relatives and representatives' comments included, "Everything is fine", "On the whole the staff are welcoming and approachable; they try to make the residents as comfortable as possible", and "They talk to her nicely."

We saw staff speaking kindly and sensitively with people, for example, when supporting people to eat meals in their rooms. Staff said this was their experience of how other staff interacted. A staff member told us, "I think the current strength of the service is the effort that the team put into improving the overall care of the residents to promote their overall health and happiness." Overall, staff communication with people was warm and friendly, and showed caring attitudes. However, we saw a few staff tending only to speak with people when spoken with, rather than taking opportunities to engage people.

The registered manager emphasised the need to undertake walk-around checks to ensure people were receiving good care. We saw them and the deputy occasionally undertaking these during our visits. This helped identify poor practices and weaker interactions.

The registered manager told us the staff handover system, which included a walk-around check of each person, was helping ensure people had had recent support with personal care. Records showed this process also enabled people using the service to be introduced to new staff, which an agency staff member confirmed was the case when they first started.

The service ensured people's privacy and dignity was respected and promoted. People told us this was the case, for example, "They always respect my privacy." Relatives and representatives mostly agreed. One told us, "They keep my relative clean and fresh at all times."

We saw staff knocking on bedroom doors and respecting dignity by closing curtains and doors during personal care. Our checks of some people's rooms found no lingering odour and efforts to keep the rooms tidy and individualised. We found people's bedding, pillows and mattresses to be clean and comfortable-looking. People who had difficulty with coordination were supported and encouraged to be independent if they could. Staff provided patient support where needed. Staff were aware of the need to be gentle when doing personal care. One staff member said, "We try and are very careful and monitor at every time we give personal care." People requiring bedrest were observed to be comfortable, warm, clean and tidy.

Staff interview records included questions on aspects of dignity and care, such as about human rights and the confidentiality of people's personal information. These matters were also discussed within the provider's induction process that all new staff attended. Records of staff and nurse meetings showed they were used to reiterate standards of care and interaction. This helped ensure staff upheld people's privacy and dignity.

There were signs up around the service reminding everyone on appropriate behaviours as this was people's home. The registered manager told us was to help ensure everyone in the building treated everyone else with respect.

The service supported people to develop and maintain relationships that mattered to them. People told us they had visitors. Comments included, "My sister visits" and "My friends and sons visit me regularly." We saw visitors welcomed into the service and able to visit at any time. Visitors told us they were welcomed at the service. One praised the nursing staff in particular, saying they were "easy to talk to and helpful." Another told us of being promptly informed about health developments. Others' comments included, "The majority of staff friendly and helpful" and "They keep me in the loop."

The service was improving their support of people to express their views and be actively involved in making decisions about their care and support. People we spoke with were not familiar with a care plan, but one person told us their family member "may be aware of my care plan." Another person's representative said, "There has been individual meetings, this was most helpful and informative, and also gave me a chance to express my own opinions." Another told us of being asked about the person's life history, which they understood helped inform the service about the person's current dementia-influenced behaviours.

Care plans did not consistently show evidence of the involvement of people using the service, or where appropriate, their representative. However, the registered manager showed us recent letters sent to people's nominated relatives or representatives, inviting them for discussions on people's preferences and routines. They also told us of an advocate continuing to visit weekly, to support people who can find it difficult to communicate. The advocate supported people to make choices, ask questions, and let the registered manager know what the person thinks of the service.

The service sought people's views through residents' meetings. Records showed there had been three of these in the last six months. Meetings were advertised in advance, and typically had eight attendees amongst those using the service plus the registered manager and some heads of departments. Feedback was sought on a range of service issues such as activities, meals and staff. There were similar meetings for people's representatives, but these were poorly attended.

Is the service responsive?

Our findings

At our last inspection, we found some complaints had not been listened to fully and learnt from. This meant the provider was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made which addressed the breach. The service was listening and responding to people's concerns and complaints, and using this to improve the quality of care.

People had no concerns to feedback about how the service addressed matters. Their representatives generally fed-back positively too. One person's representative said, "If and when I am unhappy about something I will speak to the nurses I know, or talk to the manager, who is always around and available." They also told us of care staff immediately responding to a cleanliness concern they had raised. Another person's representative told us of timely responses to two matters they had recently raised.

The service's complaints records showed formal complaints were acknowledged in writing, investigated in good detail, and outcomes were sent to the complainant within the provider's stated timescales. The outcomes explained actions relating to the complaint, apologised where service shortfalls occurred, and stated what actions were now being taken if needed. We also saw a compliment card from the family of one person where the family had complained about the service a few months earlier. This helped indicate the complaints system was working.

A staff member told us, "We listen to residents' and their families' concerns and try to address them as soon as possible." Staff meeting minutes showed reminders of how complaint procedures worked and for staff not to take matters personally or act unhelpfully. This backed up the guidance on handling complaints that new staff received within their initial induction training, and the knowledge checks that staff occasionally undertook on complaints handling. This helped assure us the provider was making sure staff knew how to handle concerns and complaints.

However, we found the service was not consistently responsive, as call-bells were not always responded to promptly. Most people in their rooms had a call-bell within reach if able to use it. One person told us, "I can ring the call-bell in an emergency." However, one person's representative told us, "Sometimes the call-bell isn't working or is not in reach." Another told us, "Often the call-bell is not answered and even after being answered the person will go away saying they will return in a few minutes, but they do not and the call-bell has to be used again."

We set off call-bells in the building three times across the inspection visits. The call-bell in one person's room was promptly attended to. However, the other two call-bells were in toilets and took at least 14 and 19 minutes respectively to be responded to. This was during and just after lunch on our first day of visiting. This was not suitably responsive.

Call-bell activations went directly to pagers held by staff. We found there were not enough pagers available for staff use on our first day. A nurse told us five were working. This meant at least three care and nursing staff could not carry one and so be informed if the call-alarm was activated. We saw records showing that more pagers were on order, and were subsequently informed of these being acquired. However, the service had not promptly addressed this issue. This put people at unnecessary risk of delays to activations of call-bells, which failed to ensure people received appropriate care that met their needs.

People's care plans provided a lot of detail that reflected much of the person's needs, preferences and routines. There was good focus on health-related matters but also consideration of holistic needs such as communication, decision-making and stimulation.

However, important information about how the person wanted or needed to be supported was occasionally missing. One person's care plan did not have any reference on how to safely support them in respect of an identified infection control matter. Another's person's catheter care plan did not include guidance on maintaining dignity, staff skills and infection control measures. A third person's plan did not specify that they were resistant to personal care such as for the long nails we saw.

Sometimes important information was only contained in the monthly evaluation of each part of the care plan. For example, one person's evaluations recently started including guidance on supporting them out of bed daily, but this was not evident if looking only at their care plan for mobility. Another person was now wearing a hearing aid, but their communications plan only mentioned this in the evaluation of the care plan. Plans did not therefore consistently provide easy-accessible guidance on how staff were to provide individualised support, risking people's care not reflecting their needs.

There was also a one-page summary of people's key needs, covering each area of their care plan. However, these were sometimes out-of-date due to the person's needs changing, plus the lack of space made handwriting sometimes difficult to read. This demonstrated failures to design care or treatment with a view to achieving the person's preferences and ensuring their needs are met.

We found two people had conditions on their authorised Deprivation of Liberty Safeguards (DoLS). The condition on one person's DoLS, requiring the service to support them weekly to their church, was not being met according to recent records and staff feedback, despite a care plan being set-up about it a month before our visit. Previous care plan evaluations this year noted the person had been asking about attending church, but there was nothing written on actions taken to support them to attend. This demonstrated failures to ensure the person received care that was appropriate, met their needs and reflected their preferences.

The above evidence demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager acknowledged there was ongoing work to make people's care plans more person-centred. This included working with the local authority's Quality in Care Homes Team. Following our visits, they also informed us that visits had been started for the person with the DoLS condition.

Staff could tell us of people's particular needs and how to provide individualised support. For example, an agency staff member knew how one person liked to eat and the prompting support they sometimes needed. They were also aware of the fortified drink the person was to have. Another person was known to prefer things to be written for them to read as they had poor hearing.

The service provided people with daily communal activities that attempted to reflect their interests. People's comments on the activities included, "I play Bingo, you know I am quite lucky!", "I really don't like to take part in any activity, sometimes I read newspaper" and "There were celebrations of festivals such as Christmas and Easter."

There was a big activity board in the main lounge showing details of each day's activity. A written weekly programme was also available. The service had activity co-ordinator support four days a week as part of a weekly activity programme. External entertainers were bought in on most other days. We saw an entertainer singing to and attempting to involve people using the service in the lounge after lunch on our first day of visiting, although we saw little being offered to people who stayed in their rooms.

We were shown photo folders of the various activities the service had provided across the last year. Group activities included flower arranging, baking sessions, sing-a-longs, exercise groups, gardening, and drama sessions. There were national themed days to reflect the various cultures of people using the service. These included quizzes, displays and meals reflecting those countries. Other important days such as Burns Night, St David's Day and Mothers' Day were also celebrated. A designated display area in one corner of the lounge showed the various results of the service's arts and craft sessions.

People's care files showed their interests and life-histories were checked on during the admission process, and hence care plans were set up to reflect how best to ensure their engagement. There were daily write-ups of what stimulation they had, and then monthly reviews by activity staff on what had occurred.

The registered manager told us people's views and feedback on sessions were sought, to make activities more involving. This had helped one person to join in, as they had been noted to tap their feet to musical entertainers. Equipment that displayed visual effects in response to sounds had been acquired, which helped the person to be more involved as they now tried to grab what they saw.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death. The registered manager told us the service did not specialise in end-of-life care but provided a service to people where they assessed that they could meet end-of-life needs or where people using the service had progressed to end-of-life care. End-of-life wishes were checked as part of the service's assessment process. This included cultural and religious needs and wishes pre- and post-death.

Records and staff feedback informed us of regularly liaisons with community palliative care professionals, including for the management of people's pain-relief medicines. We saw people receiving pain-relief medicines on request. Medicines records showed these were used where needed. People's care plans included pain-management assessments and plans.

Is the service well-led?

Our findings

The service's new manager had been in post for nine months at the time of our visit. They had successfully been registered with us for that role, indicating appropriate capability, qualifications and experience.

At our last inspection, we found the provider's Duty of Candour policy had not been followed in respect of two incidents. This did not reflect a culture of learning from incidents to minimise the risk of reoccurrence. This meant the provider was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements were made which addressed the breach. The registered manager was clear on duty of candour responsibilities, but told us no-one had recently sustained an injury or developed a pressure ulcer that fell into that category. Previous notifications showed that duty of candour processes were being followed, including writing to the person or their relevant representative when things may have gone wrong. The registered manager told us it was important to apologise in these circumstances, openly explain what happened, and if things had gone wrong, to ensure that lessons learnt were dissipated amongst staff such as through memos, knowledge checks and staff meeting, to prevent a reoccurrence.

The service was aiming to promote a positive and inclusive culture that achieved good outcomes for people. We found both the registered manager and regional director to present openly about the strengths and ongoing challenges relating to the running of the service. For example, they shared documents that identified service weaknesses but could tell us of plans for making improvements.

The registered manager acknowledged there had been a high turnover of staff. They told us of addressing poor practices and interactions amongst some of the staff team, including through disciplinary procedures where necessary. The net effect was an improving working culture at the service in terms of safety and more respectful outcomes for people. However, there was further progress to be made. A community professional confirmed this to be their experience, and that the service was working openly with them to improve services. This helped demonstrate the transparent approach of the management team.

People provided positive feedback about the service's management. Comments included, "I know the manager", "The management is very good" and "My son is in contact with the manager." Most relatives and representatives praised the service's management. Comments included, "The manager is excellent" and "The manager is always around and available, which I feel is good as she is aware of what is going on." However, another comment was, "The management do not really listen." Community professionals all fed-back positively on the service's management, for example, describing the registered manager as "proactive."

Most staff told us they felt supported and that the registered manager was approachable. The service held meetings for all staff every other month. Minutes were also kept of meetings specifically for nurse and for heads of departments such as cooking and housekeeping. Records showed the meetings enabled concerns to be discussed, helped reiterate standards of care, and updated staff on changes in the service. There was also praise and recognition of good work.

The registered manager told us of trying to utilize the skills people in the staff team had. Two staff had therefore secured promotions. Further work was planned for developing senior care staff roles, to tie-in with development of people's care plans.

The provider circulated updates on policies and news that may affect staff. Recent examples included details on recognition and rewards schemes, plus how new data protection legislation was changing the provider's practices. The management team had signed off a checklist for compliance with these changes, and staff had received specific supervision on these points. Records showed staff were similarly updated on the provider's implementation of a new online human resources system including for staffing rosters and timesheets.

The provider's governance framework was designed to ensure that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. The service held quarterly health and safety meetings, to help keep safety matters across all departments under review. There were regular specific audits of key areas of the service such as for medicines, infection control, staff personnel records including the nursing register, and health and safety. These helped to check that appropriate safety standards were being maintained or flagged for improvement.

A monthly oversight report of the service was kept that consider quality and safety indicators such as pressure ulcers, safeguarding cases, complaints and incidents. These considered updates and trends over time. The registered manager also showed us weekly monitoring reports that were sent to the regional director. These reported on key performance matters such as amount of agency staff use, recruitment progress, occupancy matters and safeguarding cases.

The regional director undertook monthly reviews of the service, to consider a range of factors such as people's quality of life, food, and the environment. Reports were realistic in identifying what worked well and what needed changing or improving. These fed into the service's overall improvement plan, and we saw records of discussing aspects of these in nurse meeting minutes.

However, we identified a breach of regulations for person-centred care, which is described in detail under 'Is It Responsive?' The service's auditing processes had not identified and addressed the matters causing this breach, which demonstrated weaknesses in the provider's governance framework. This meant the service was not consistently well-led.

The provider engaged with and involved stakeholders in the development of the service. The last annual survey of people using the service, in late 2017, reported positive feedback across key aspects of the service from the 15 people surveyed. Nonetheless, the registered manager set-up an improvement plan to help address weakest areas identified, and signed it off when completed.

Systems at the service enabled sustainability and supported continuous learning and improvement. On our second unannounced day of visiting, the registered manager told us of actions taken following feedback on the first day. For example, records of immediate supervision were held with two staff members after the registered manager saw them unsafely move and handle a dependent person, for whom further training was also being planned.

The service worked in partnership with other agencies to support care provision and development. The registered manager told us of inviting the local authority's Quality in Care Homes team to visit and provide support where appropriate. Members of this team were present during the inspection, observing and assisting with hoist training relative to the needs of people using the service and staff. They informed us of

good collaborative working in support of achieving better outcomes for people. We saw work plans relating to this, which showed gradual improvements in identified areas.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered persons failed to ensure that the care and treatment of service users was appropriate, met their needs, and reflected their preferences. This included but was not limited to failing to design care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9(1)(3)(b)