St Dominic's Limited

Raj Nursing 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

About the service:
Raj Nursing Home is a care home that is registered to provide personal and nursing care for up to 28 older people, some of whom are living with dementia. At the time of the inspection 24 people were using the service.

People's experience of using this service:
At our last inspection we found a breach of the regulations relating to safe care and treatment. This was because some aspects of the environment were not kept in a safe manner. At this inspection we found safety in those areas that previously had been a cause for concern had been improved. During this inspection we still found some areas that might pose a risk to people, that had not been identified or addressed by the provider.

During our inspection people told us they received their medicines in a timely manner. Whilst medicines administration records were completed by the nursing staff appropriately, some information had not been updated to reflect people's current medicines regimes.

At this inspection we also found that care plans were not person centred because they did not contain background information relevant to the person and did not always contain what support people required with their diverse needs. Care plans did not state what activities people might enjoy and we found a lack of meaningful activities in the service.

There had been no registered manager in post since August 2018 and there had been several changes in manager since our last inspection. The current manager had applied to register with the CQC. The provider ensured they were present in the service to support the manager to make identified changes, but difficulties recruiting staff, in particular nursing staff had impeded this process. Therefore, whilst the provider had undertaken checks and audits and had in place a comprehensive action plan there was a delay in making some planned changes to the service provision.

The manager had assessed staffing needs in the home and put in place additional staff if someone had a higher support need. Notwithstanding this, most people and relatives told us staff were often very busy and said there was sometimes a delay in call bells being answered at key times in the service.

At our last inspection we found a breach of the regulations about the need for consent. At this inspection we found this had been addressed and care plans we reviewed were signed by the person or their legal representative to show they had agreed with their care plan. We saw also that the manager had applied for Deprivation of Liberty Safeguards on behalf of people who were assessed as not having capacity to consent to their care and treatment.

People described staff as caring and friendly and said despite them being busy they made time to talk with

them. We saw staff were respectful towards people and asked their permission before supporting them. People said staff maintained their privacy and dignity.

People told us they liked the meals provided and there was a picture menu to choose from and alternative meals were offered. People with dietary needs were supported and staff encouraged all people to have enough to drink. The provider ensured people had access to health and social care professionals to maintain their well-being.

Rating at last inspection: At the last inspection on 10 May 2018 we undertook a focused inspection for the key questions safe, effective and well-led and rated these requires improvement and therefore the overall the rating was requires improvement.

Why we inspected: We brought the inspection forward because a Healthwatch visit on 8 January 2019 had identified concerns about staffing levels and support for them, the lack of a menu and activities for people on the day of their visit.

Improvement action we have told the provider to take: Please see the actions we have told the provider to take section towards the end of the report.

Follow up: We will ask for an action plan from the provider to address the areas where improvement is required. We will continue to monitor the service and will re-inspect based on the rating of requires improvement. We may re-inspect earlier if we receive concerns about the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Raj Nursing Home

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team consisted of an inspector, a special advisor who was a pharmacist 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.

Service and service type: Raj Nursing Home is a care home that is registered to provide personal and nursing care for up to 28 older people some of whom are living with dementia.

At the time of our inspection there was not a registered manager in post. A registered manager is a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:

Before the inspection we considered all the information we held about the service. This included the last inspection report and the provider's action plan in response to this. We looked at notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

We reviewed three people's care records and sections of two other people's care plans. We looked at twenty-four people's medicines administration records. We spoke with twelve people using the service and two people's relatives. We observed staff interaction with people throughout the day. Our observations

included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We undertook a partial check of the environment.

We looked at three staff personnel files. This included their recruitment and training records. During the inspection we spoke with the manager, the area manager, the quality assurance manager, a nurse, one senior care worker, one care worker and the chef. We also spoke with a visiting social care professional and two healthcare professionals.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management

• At our last inspection in March 2018 we identified several risks to people, in relation to the premises. These included items left on the patio that were trip hazards and a lack of radiator covers. At this inspection those risks had been addressed. At the last inspection we were also concerned because stairways were accessible to people living in the home and there was no risk assessment in place about their use and the possible risk of falls. At this inspection we found the main stair way now had key pads that required codes to enter at the top and the bottom of the stairs. This was to restrict people from using them if it was unsafe for them to do so. However, we found the rear stairway was also accessible to service users and was still unsecured with no key pads. We brought this to the provider's attention. The provider explained that this stairway was a fire exit and it was required that it remained accessible always for people's use. However, this decision was not recorded as risk assessed in the environmental risk assessment. The provider sent us a risk assessment immediately after the inspection visit to reflect their assessment of this risk.

• We found that risks in relation to people accessing the garden had been reviewed and mitigated but we brought to the provider's attention that some paving at the rear of the garden and a ramp to access a doorway might pose a trip hazard to people mobilising independently. There were also a laundry and a maintenance room situated in the garden area both had been left unsecured and unattended. The laundry room contained detergents and electronic equipment and the maintenance room was used to store equipment and items that might pose a risk to people with access to the garden area. We brought these concerns to the provider's attention who agreed to address them with staff.

• The provider had assessed risks in relation to people's care and had put in place guidance for staff to mitigate those risks. Risks identified included, falls, behaviour, moving and handling, mental and physical health conditions. The provider used recognised tools to assess the risks of malnutrition and those associated with skin integrity. Where risks were identified guidance to staff to mitigate these was in place.

• The provider had fire prevention measures in place. For example, there was a dedicated smoking area for people who wished to smoke in the garden with appropriate bins for the disposal of cigarette butts. There were personal emergency evacuation plans in place for each person in the event of a fire. There was a fire action plan with an assembly plan. Fire alarm checks were done weekly and there were fire drills. For example, a fire drill, took place on the 19 January 2019. There was a visual check of the firefighting equipment and fire doors each month and fire exits were kept clear. A consultant checked equipment once a year. The fire risk assessment was due to be reviewed at the time of our inspection. The quality assurance manager had identified this and agreed to send us the reviewed risk assessment once it was completed.

•□The provider undertook environmental safety checks. These included, checks to ensure the water system in the home was safe. There was a Legionella risk assessment and flushing of all hot and cold unused water outlets. There were four pre- planned visits a year by a contractor for plant maintenance to manage the risk of Legionella. The first visit for this year had already taken place in February. We also noted that a gas safety check had been done in March 2019, a five-year electric wiring installation check in July 2018 and monthly checks of window restrictors, bedrails and moving and handling equipment took place to help ensure the ongoing safety of people using the service.

Using medicines safely

•□People told us they got their medicines at the right time, for example one person said, "They bring me my medication and watch me take it. Then they write it down and I do get it at the same time each day." We checked all people's medicines administration records (MAR) and found that they had been completed appropriately without omissions.

•□However, we found a few concerns where information had not been updated appropriately so people received their medicines as prescribed. We saw for example that one person's medicines had not been reduced as the consultant psychiatrist had requested in a medicines' review letter dated January 2019. This oversight had not been identified by the provider but was identified on the day of our inspection in a visit by a healthcare professional.

•□The administration of covert medicines was only done when a mental capacity assessment had been undertaken that demonstrated people did not have capacity about their medicines. Both the GP and the pharmacist had been involved in the best interest decision to administer medicines covertly. We noted a covert administration consent form was in the MAR records for one person. The nurse indicated to us that this person was now compliant with medicines and was no longer having their medicines administered covertly.

•□The storage of medicines was appropriate and there were systems for the collection and disposal of medicines. We read that one person self-administered their own medicines from a weekly supply provided by the staff in a multicompartment aid. The person's medicines were to be kept in a medicines' cupboard in their bedroom so they could remain independent. However, we noted that, the medicines were stored near their bed as this was the person's choice. We found that the risk that the medicines could be easily accessed by anyone going into the room had not been assessed and mitigated.

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

Staffing and recruitment

•□A Heathwatch visit in January 2019 found staffing levels were low on the day of their visit. We were told by the provider this was because of staff absence on the day. During our inspection people and relatives told us they were well looked after but described staff as rushed at times. Their comments included, "I have regular carers usually. The staff are so busy and there are just not enough," and "It's busy at night and they are running around," and "I try to be very patient but I have to say you do wait quite a while for assistance and especially in the morning and after lunch." Three people and two relatives told us there was a delay sometimes in call bells being answered. They said, for example, "Bells get answered very slowly. I understand that other people need help too and they are very busy here. I use my bell and they do not come quickly, night or day," and "Usually you don't wait that long, sometimes 10,15 minutes maybe 20 minutes at night but that is only sometimes."

•□The manager told us that during the day shift they worked on a ratio of one care worker to five people, this did not include the nursing staff who were there to oversee each shift and give clinical support. We saw this was reflected on the day of inspection and in the staff rota. At night times there were two care workers and one nurse on duty. The manager explained that when someone had higher support needs they would request an extra bank staff. We saw on the first day of our inspection one person had a hospital appointment and an extra staff member had been rostered on duty to accompany the person. During our visit we observed staff were very busy during some key times such as after lunch when the call bells were ringing a lot as people required assistance at the same time. However, we did not observe people waiting for long periods. Following the inspection, we brought to the providers attention that some people felt they were waiting too long for assistance in particular at night. The manager told us that currently they monitored the call bell response times by listening and investigating if they were over five minutes in duration. They had also approached the call bell company to ascertain if a call bell report could be generated from the system to monitor electronically. This would allow them to investigate response times when they were not present in the service.

•□In addition, to the senior and regular care workers and a nurse there were staff who had supporting roles such as the housekeeping staff, a chef and an administration officer. The registered manager told us they were recruiting for an activities co-ordinator as the previous one had left the service. The registered manager had some established permanent care staff. However, they told us they had experienced a high staff turnover and had difficulties recruiting staff, in particular nursing staff. They felt the lack of permanent staff had impacted on implementing new systems that they felt would improve the service. This included a delay in rolling out an electronic care planning system.

•□The provider followed their recruitment procedure and took appropriate steps when recruiting new staff. Staff were asked to complete an application form and attend an interview to assess their aptitude for the role. Following a successful interview, the provider undertook checks of staff identity, requested and received references from former employers and asked for a criminal record check to be completed. The registered manager told us that they felt it was very important to get the right staff for each role as they wanted to build a strong and effective team. They said, "I don't want just to fill the post, we need [staff of] the right calibre and we need continuity."

Systems and processes to safeguard people from the risk of abuse
•□People and relatives told us they felt safe and well looked after at the home. Their comments included, "I feel safe…everyone looks after me and my things. I do not worry which I feel reassured about," and "[Person] is very safe here. I don't worry about anything. They take good care of them."

•□Staff had received safeguarding adult training and told us how they would recognise and report signs of abuse. Staff comments included, "First inform the nurse, if abuse they inform the manager then decide if a safeguarding adult, a very big issue. Bruise, red skin or bed sore immediately inform the nurse where the body mark is," and "The way the residents behave, aggressive or agitated when they are usually happy go lucky, it strikes you something is wrong. Inform the line manager and find out from other colleagues if something has gone wrong or something has happened. I would go higher if necessary [whistle blow]."

•□The registered manager reported safeguarding adult concerns appropriately to the local authority and informed the CQC. They demonstrated they investigated and were open and transparent about their findings. They kept an overview of safeguarding adult concerns to identify outcomes and trends in the service to ensure learning took place.

Learning lessons when things go wrong

• The manager told us how they learnt from incidents, accidents, complaints and safeguarding adult concerns. They described they shared knowledge from investigations with the senior staff in their daily handover 'huddle' meetings and with all staff in meetings, supervision and training.

• They gave an example of learning from a safeguarding concern where an issue reported to the person in charge was not followed up. Following an investigation and the safeguarding adults process, the provider invoked their disciplinary procedures. The registered manager also shared the learning from the mistake and involved other staff in getting their views about how to prevent a reoccurrence.

Preventing and controlling infection

• People and relatives told us that staff kept the home clean, their comments included, "It's okay, they're very clean, they look after the place," and "It is very clean here, they work really hard." We found the service to be clean during our visit and the kitchen had a five-star rating from the local authority in 2018 indicating a high level of hygiene.

• Staff had received infection control training and used personal protective equipment to avoid the risk of cross contamination. The provider undertook checks and a monthly infection control audit to make sure that staff were adhering to good practice.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good:People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
•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.
• We saw that mental capacity assessments had been undertaken when there was a reason to believe the person may not be able to make a decision because they lacked the capacity to do so. Assessment seen were specific to a particular decision and included medicines and care and treatment.

•At our last inspection in March 2018 we found a breach of the regulation in respect of consent. This was because people or their legal representative had not signed their care plans to indicate they agreed with how care was provided. At this inspection, in plans we reviewed, we found that people had consented to their care or the appropriate legal requirements were in place for the provider to act in their best interest.

•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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We found that the manager had applied for DoLS authorisations on behalf of people who they had assessed as not having capacity to consent to their care and treatment and who may have been deprived of their liberty. People's records contained their DoLS authorisations and there was information for staff that explained what conditions were in place and what this meant for the person.

•We observed staff offering people choice throughout our visit. Staff told us they had received training about MCA and newly recruited staff told us they had been briefed by the manager about MCA and were going to have training soon. Their comments included, "MCA means if they have dementia and they can't make proper decision, because for example, they are unaware of time, place and person, someone does a mental capacity assessment. DoLS means Deprivation of Liberty Safeguards, if they are unaware and can't make a decision we apply for DoLS and it shows we make decisions of best interest for them," and "MCA, no training yet but it was explained to me. It is the ability of a person to make a safe choice for themselves. In case the person cannot, especially many residents with dementia, in that case we apply for a DoLS to keep them safe."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□The manager assessed people's needs prior to admission. They told us that they read through professional's reports and undertook a face to face meeting to assess if staff could meet the person's support needs. They gave an example that if the person would require two male care workers and they did not have two permanent male care workers they would not accept the person. They wanted to achieve a "good balance" in the home so they could meet everyone's care needs.

•□The manager told us they undertook the assessment to identify specific needs such as the nutritional and eating support required and establish if there was speech and language therapist involvement. They explained they have a conversation asking about the person and to establish what diverse support needs they might have. "Like to go to the Gurdwara, if family are visiting, if they like a radio programme, their favourite foods…have a conversation about past history." They also encouraged the person or their family to visit the home prior to admission.

Staff support: induction, training, skills and experience
•□Staff told us that they had received an induction prior to commencing their role. One staff employed just prior to our inspection told us the training was good, "Especially manual handling training with other staff. The trainer showed me how to use the hoist…we have five trainings that are mandatory, also we are introduced to the residents and told their different timings [for personal care]." The manager told us, "Online mandatory induction training they must do before they finish their induction… induction lasts until I feel they are confident and will do their work well. I get feedback from senior staff. Two days of shadowing work with a senior staff or two weeks longer if needed."

•□We found that all care staff had received basic training to undertake their role, this included, dementia care, health and safety, fire safety, infection control, moving and handling and safeguarding adults from abuse. The manager told us that they wanted to provide further training opportunities for staff and we saw evidence they were in the process of planning new training courses so staff would be able to extend their knowledge and skills.

•□Staff confirmed they felt well supported and received supervision sessions. One senior care worker told us, we have supervision with the manager and with [Quality assurance manager] also." They confirmed they found these sessions helpful. The manager explained they aimed to provide supervision every three months, a supervision audit tool showed that all care staff had received supervision sessions in January and February 2019.

Supporting people to eat and drink enough to maintain a balanced diet
•□People told us they had a choice about where they ate their meals and were asked their preferences from the menu. Their comments included, "I eat in the dining room, I don't want to be on my own in my room. I like being around people and seeing what is going on. The food is nice and I choose. You can have other things not on the menu like omelette," and "I like to choose smaller food so I have a baked potato or a sandwich at lunchtime. I like the food and they give you more than enough," and "It is very nice. You get choices and you choose when they come around in the morning…I don't need help but they do offer to cut food up. I choose to eat in my room sometimes and that is fine."

•□We observed there was a variety of meals to choose from a picture menu and when people requested they were provided with an alternative. Meals were served if people wanted with a side salad, relish or chutney. Menu choices included, both traditional English and Asian dishes. People's dietary requirements were met, including those related to their cultural background or health condition.

•□The chef and the manager both told us they had improved people's meal time experience and we saw people were choosing to sit together and talk during lunch time. There was a friendly atmosphere in the dining area. The manager told us that they always tasted the food prior to it being served to ensure it was tasty for people. They explained, "I'm a critic so I make sure it's good, when you cook you need to taste." The chef, who was new to the service asked people following their meals if they enjoyed the food, and noted what people liked.

•□Staff supported people who required support to eat. This was provided both in the dining area or in people's bedrooms. People's food was cut up or pureed according to their dietary requirements. One relative told us, "They help [person] to eat …and they are very patient and [person] is always clean afterwards."

•□The staff ensured people had enough to drink. One person told us, "They bring them [drinks] all the time or you just ask and they make you one. I have a water in my room and I can usually reach it." Drinks were served throughout the day and with meals. When people were in bed a cold drink was left by their side. One senior care worker told us the manager was very particular about ensuring people had enough fluids throughout the day and had instructed staff to sit with people and encourage them to drink.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
•□People told us they were supported to see healthcare professionals. Their comments included, "I ask to see the GP and they come along, usually the next day. It's well organised. They arrange opticians to come here for me," and "They do get them out within the day usually and over the years I have regularly seen the GP. I've seen the foot doctor regularly and the opticians come in."

•□Health and social care professionals we spoke with confirmed that the staff were proactive in asking for support in particular the established staff members. One social care professional said they found the staff were respectful towards the person they visited. We observed that people were supported to attend hospital clinics when they lacked capacity to understand what was taking place and if there was no family member to accompany them.

Adapting service, design, decoration to meet people's needs
•□Since our last inspection two bedrooms had been added to increase the capacity of the home. The bedrooms were completed and ready for use. There were still some minor issues on the extension to be addressed to complete the refurbishment.

•□The home although not purpose built was wheel chair accessible and had a lift to the upper floors. There were hand rails in the corridors to support people to mobilise independently. There were memory boxes on the wall outside people's bedrooms with their photo or an item of memorabilia they would recognise to help them find their bedroom. There was some signage in the home to support people to orientate themselves. The garden was generally well kept and had a few sensory herbs such as lavender and rosemary to improve people's experiences of walking around.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good:People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
•People and relatives described the staff as friendly and caring. Their comments included, "It is okay and sometimes it has a nice atmosphere. The carers are fantastic," and "I am very happy with it here. There is a nice atmosphere and the carers chat with you," and "Yes, [Family member] has a regular carer and they are fantastic. They are very, very good here," and "They are lovely and never too busy to talk," and "They are very nice and always happy. They give me a little hug if I feel rubbish."

•Staff told us they were encouraged by the manager to make time to talk with people. One care worker told us, "They encourage here to spend thirty minutes [with people]. [Manager] likes to ensure we spend more time and communicate, make a good relationship with them, we make a bond." We observed staff interaction throughout the visit and found staff to be responsive to people's needs and they treated people with respect and patience.

•Staff were respectful of people's diverse needs and could often speak with people in their preferred language. They had a good understanding of people's cultural and religious observances. We saw when staff were unable to speak a person's preferred language they had learnt a few words to help them communicate more easily with the person. Some people practised their religion and had shrine or religious items in their bedroom and there was a visiting church group. The chef made a variety of traditional English and Asian meals that they thought people might like and were actively asking for ideas from people.

•We saw that the quality assurance manager had a meeting with staff to discuss aspects of diversity and to support staff understand the need to avoid stigma in the home. Staff told us they had discussed diversity with the quality assurance manager and would make people from the lesbian, gay, bisexual and transgender plus (LGBT+) community welcome. One care worker said, "Nowadays it is normal, we would treat them like the other residents, here we speak in Hindi or a language people understand so they feel at home, we would do that for gay people, make them feel at home."

Supporting people to express their views and be involved in making decisions about their care
•People and relatives told us staff asked people's permission and gave them choice before supporting them. Their comments included, "They ask before they assist with personal care if they can do it, I hear them regularly," and "They all ask before they do something like helping me sit which occasionally I need help with. They ask me if I would like help with my socks or getting dressed."

•We observed staff offering choice and getting people's permission before they acted, this included for example, asking if they would like to wear a clothes protector, if they are ready to have their lunch, where

they would like to sit and what drink they would like. We saw that one member of staff used lots of encouragement and praise when supporting someone to eat their meal and asked them would they like to taste the food first before deciding if they wanted to eat it.

Respecting and promoting people's privacy, dignity and independence

• People and relatives told us staff usually knocked on their door before entering and supported them to remain independent. Their comments included, "I feel [Person] still has respect and dignity. The staff are very good at putting them at ease and [Person] relaxes so they don't have to struggle with them. This leads to less assistance needed," and "I still have my independence and dignity. They are very discreet here." We observed that staff usually knocked on people's doors before entering, although there were a couple occasions when we noted that staff did not always do this. We brought this to the attention of the manager.

• We observed staff speaking to people discreetly asking them if they wanted support with personal care and staff used a screen when hoisting people in the lounge area to provide privacy and maintain their dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•People's care plans were not always person centred. We looked at people's paper records and noted these were in the process of being updated and transferred to an electronic care planning system. Paper records reviewed contained good guidelines for staff to support people in some respects but contained little or no information about people's history or background unless it was related to their immediate health care. As such, there was not information about people's backgrounds or important events and achievements in their lives. This lack of information meant that staff were not being supported to understand people in the context of their lives.

•In addition, although people's diversity was respected in terms of their culture and religion, this was not always reflected in their care plans. Whilst care plans stated the person's religion in terms of dietary need, they did not always detail if people required support to attend a church or temple. We saw for example, one person had a shrine in their bedroom but it was not referenced in their care plan. Therefore, staff might not have had the necessary information to support people with their spiritual needs.

•People's care plans did not specify what activities people might enjoy. There was an occasional reference but it was often brief. For example, one person's plan said that football was one interest but it was not stated if they liked to watch or listen to football match commentary or if they had a favourite team. In addition, under another section it stated the person was unable to take part in activities so to offer one to one activities. There was no reference as to what this one to one activity might be.

•The provider had recognised that care planning around activities needed to be more specific and electronic records had started to address this. However, when we checked them staff had filled out prepopulated answers that were not correct for the person. The quality assurance manager agreed that the electronic records were still, "Work in progress."

•People and relatives told us, "I like my room because there isn't much going on in the lounge," and "They do no activities and [Person] is very bored," and "Activities used to get cancelled because of staff being off and that hasn't really got better," and "I like to read and watch movies downstairs and I can do that if I ask about the movies and I have everything to do that in my room. There isn't much going on but sometimes they invite me to a sing along or to play Bingo. I would like to visit parks and do some gardening," and "A bit more activity, I get bored and fidgety" and "[Person] would like some manly things like war films, sports on TV and trips out."

•During the two days of inspection we did not see that people were engaged in meaningful activities. A television was on in the communal areas but no activities were taking place and people were not being

engaged in activities in their rooms. Whilst staff spoke with people in a chatty and friendly manner and attended to their support needs people were not engaged in an activity that stimulate or interest them.

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

•□The provider was aware of the short comings about activities. An activities co-ordinator had been in post but had given notice shortly before the inspection. We noted that the provider was advertising for a replacement staff member for this role. Notwithstanding the above there had been some celebrations such as a dance troop at Diwali and cake making. Bingo and sing along and some other activities had taken place when the activities staff had been in post. The provider had a, "Resident of the Day," programme and checked each person's records, clothes, favourite food was cooked for them and an individual activity with them such as going for a walk to the shops or café. People's birthdays were celebrated and cultural events such as Easter and Christmas were celebrated as well.

Improving care quality in response to complaints or concerns
•□There was a complaints procedure displayed in the communal area for people and visitor's information. Staff had received training about reporting complaints to the nurses or manager to ensure they were addressed.

•□The manager demonstrated that they acknowledged and investigated complaints. There had been three complaints during the five months prior to our inspection. The manager screened complaints and raised them as a safeguarding concern with the local authority and notified the CQC if that was an appropriate action to take. Complaints were responded to and action was taken to address the concern with staff where required, and lessons were learnt and changes were made to ensure the same error was not repeated.

End of life care and support
•□People had end of life care plans that gave some information about what they wanted to happen at the end of their life. Some people had Do not attempt cardiopulmonary resuscitation (DNACPR) forms in place these had been signed appropriately by the GP. Other people had stated in their care plan record that they wanted cardiopulmonary resuscitation (CPR) to be attempted in the event this was required. In addition, care plans reviewed contained information about people's funeral preferences and who they would like to be consulted in the event of their death.

•□The manager confirmed staff did have end of life training as part of the dementia training module. They described they had looked after someone at the end of their life recently and they were 'proud' of the staff as they had worked with the GP to make the person's last days so comfortable. The manager had also identified end of life as an area where they wanted staff to have further training. They showed us they had identified a training course for staff that would support them to understand aging, death and bereavement. They also planned to contact a local hospice to see what support and learning might be available for key staff members.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

•At our last inspection in March 2018 we found a breach of the regulations about good governance. During that inspection we found that the provider's quality assurance processes and systems for auditing and monitoring the quality of the service were not very effective because these had not identified and addressed all the shortfalls we found at that inspection.

•At this inspection we found that whilst previous concerns identified had been addressed we identified a few other concerns. These included a number of risks associated with the premises that the provider had not assessed, identified or mitigated to help ensure the safety of people.

•During our inspection there was a continual bleeping noise from a door guard in a ground floor bedroom as the battery required changing. The door guard was not in working order and the door was propped open by a small table. The noise was distressing to the person lying in bed in the room, they called out throughout the day to express their dislike of the noise. We were told batteries were on order but these had not been in stock should any door guards in the service require battery replacements.

•We found some shortfalls with the management of medicines that the checks and audits carried out by the provider had not identified so these could be addressed. We also found that staff had not recorded the daily checks that air pressure mattresses were maintained at the correct pressure, as required. This had occurred because of changes to the electronic care records system. This was addressed immediately by the provider when we brought it to their attention.

•We found that care plans were not person centred in some respects and there was a lack of meaningful activities in the home. Whist the provider had identified and was acting to address some of the above concerns they were not addressed at the time of our inspection and people continued to spend their time without being engaged in stimulating and meaningful activities that met their individual needs

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

•Notwithstanding the above, the provider had undertaken a quality assurance audits and had in place an action plan that identified most of the concerns we found at the inspection. They told us that difficulties in

recruiting a stable staff team, in particular finding the right calibre of nursing staff had impeded the speed at which they had hoped to implement the new systems. As such the electronic care planning system which they envisaged would be speedier for staff to use and would contain more person-centred detail that could be updated quickly, was not yet up and running at the time of our inspection.

•□The manager and clinical nursing staff undertook monthly audits that included, care plans, falls analysis, meal times, weight monitoring, training matrix, equipment and environment, cleaning audits and safe food audits. The manager undertook three monthly audits that included, medicines, infection control and health and safety. The quality assurance manager undertook a three-monthly home review audit and had a continuous improvement plan.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•□The management team had clear roles. Staff told us that the manager was supportive. Their comments included, "Good, everything is good. She is a hard worker and is doing very well. Always when we need a hand always helps," and "Well support yes, supported a lot, especially the manager and other staff very helpful…I feel especially the manager works hard, does her best." The manager was working towards making changes in the service to improve efficiency and responsiveness. The manager told us, "I'm aware of the things as a matter of urgency. I'm aware I'm working towards it. Care staff all work so hard the last few months…. If I see something is wrong I deal with it straight away."

•□The manager had good lines of communication, they held a daily 'huddle' meeting with senior care staff, chef, nurses and senior management to ensure information about each person was passed on. There had been staff meetings and group training on pertinent issues to address practice issues and to reinforce procedures. The manager told us there was a 'one pot' meal for the staff team every Wednesday. They would sit at an activity table and share food and eat together. This was team building the manager told us, "I can see the difference … see myself as their colleague, it's a team and team work."

•□The manager told us they were well supported by the area manager and the quality assurance manager one of whom was usually present in the home. The manager told us the area manager phoned each day, "They call me every day to check and is quite precise and helps me to prioritise." They also felt well supported by the quality assurance manager" they are the first one to guide us through and supports hands on as well as giving advice."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•□Most people and relatives were positive about the manager and management team. They told us, "The manager is a lovely person. The area manager is a bit busy but does say hello, "and I know everyone here. The manager is very nice. they sit to chat and doesn't lean over you like some but they do rush off quick," and "You ask for manager and they come up within the afternoon. They will sit with you to chat and I feel listened to" and "If you need to talk or call, they call you back quickly and make time for you. They answer questions and find out info for you quickly."

•□The manager held meetings with people and asked their opinions about relevant issues such as menus. People confirmed this. They said, "We are told at breakfast time and they remind us. They do sometimes have a meeting for residents and you tell them what you think and they answer questions like what food would you like? You don't see many changes to it though," and "They remind me in the morning what is going on and if I have any visits. I never see meetings advertised but I do usually get asked if I would like to

make any suggestions."

Working in partnership with others

• Health and social care professionals were positive about the management team and said they asked for support and contacted them if they required a visit or advice.

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 The provider did not ensure that service users always received care and treatment that met their needs and preferences and in a person centred way. Regulation 9(1)(2)(3a)(3b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that all risks to people were assessed in a robust manner and that medicines were always managed safely. Regulation12(1)(a)(b)(d)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality of the services provided to service users. Regulation17(1)(2)(a)(b)(c)