Bupa Care Homes Limited

Old Gates Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This was an unannounced inspection which took place on 15 and 16 February 2017. There had been a change to the legal entity providing the service in February 2017. This was the first inspection since the new provider had taken over the running of the service.

Old Gates Care Home provides accommodation in three units, for up to 90 people who need either nursing or personal care and support. These units are Cherry, Holly and Rowan. Care and support for people living with a dementia is provided in Rowan. There were a total of 72 people using the service on the days of our inspection.

The service did not have a registered manager in place. A new manager had been in post at the service since January 2017. They told us they intended to apply to register with CQC as the manager of the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was supported in the running of the service by a newly appointed clinical services manager and three unit managers.

During this inspection we identified five breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. These related to staffing arrangements on the unit for people living with a dementia, recruitment processes which were not sufficiently robust, a lack of effective systems to ensure people received safe and appropriate care, limited evidence of person centred activities particularly for people living with a dementia and a lack of effective leadership in the service. You can see what action we have told the provider to take at the back of the full version of the report.

We identified a lack of leadership in the service particularly on Rowan and Cherry units. Staff were not appropriately deployed on Rowan unit to ensure people visiting or living and working in the unit were properly protected; this resulted in a number of serious incidents being witnessed by the inspection team on the second day of the inspection. Risk assessments and risk management plans did not contain sufficient information to guide staff on how best to support people whose behaviour might challenge others. Risk assessments were not in place for a person who was identified as being at risk of falling and choking; this meant staff might not be aware of the care the person required to minimise these risks. We also found that changes in people's behaviour had not always triggered a review of relevant risk assessments and risk management plans; this meant staff did not always have up to date information about the best way to respond to people's needs.

We found evidence that people who used the service, particularly those on Rowan unit, had not always received their medicines as prescribed.

The recruitment process in the service needed to be improved in order to properly protect people from the

risk of unsuitable staff. Additional checks had not always been undertaken when staff had worked previously with vulnerable adults or children to ascertain why their employment in that service had ended. Records did not show that gaps in one applicant's employment history had been explored.

People on Holly and Cherry units were generally satisfied with the range of activities available to them. We saw that, although objects were available for staff to use on Rowan unit to interact with people who used the service, none of these were utilised when people became distressed or exhibited behaviour which might challenge others. There was a lack of individualised and person centred activities on this unit which meant the well-being of people who used the service was not always promoted.

People who were able to express a view told us they felt safe in Old Gates and that staff were always kind and caring. Staff had received training in safeguarding adults. They were able to tell us of the correct action to take should they witness or suspect abuse.

People were cared for in an environment which was generally clean. Procedures were in place to prevent and control the spread of infection. Regular checks were made to help ensure the safety of the premises and the equipment used. Systems were in place to deal with any emergency that could affect the provision of care.

Staff received the induction and training they required to be able to deliver effective care. We saw that appropriate arrangements were in place to assess whether people were able to consent to their care and treatment. Where necessary applications had been made to the local authority to authorise any restrictions necessary to ensure people received the care they required.

Systems were in place to help ensure people's health and nutritional needs were met. Records we reviewed showed referrals had been made to specialist services such as dieticians when any concerns were identified. People who used the service told us the quality of the food was generally good.

Staff told us they would always promote people's independence as much as possible. We observed a member of housekeeping staff encourage a person on Rowan unit help them in their routine; this had a positive impact on the behaviour of the person concerned.

Although care records had been regularly reviewed and updated, there was limited evidence that people who used the service or, where appropriate their relatives, had been involved in formal review meetings. However, none of the relatives we spoke with had any major concerns about the care and treatment their family member received. .

Systems were in place for receiving, investigating and responding to complaints. The provider kept a central record of all complaints in order that any themes and trends could be identified. All the people we spoke with during the inspection told us they would be confident that any concerns they reported would be listened to and action taken by senior staff to resolve the matter.

Although staff told us they considered the overall management of the service had recently improved, we identified a lack of leadership on both Cherry and Rowan units. This resulted in staff not being appropriately directed to ensure people's needs were safely met.

Quality assurance systems in the service were in the process of being improved. The clinical services manager had begun to work with staff on the units to improve the quality of records and auditing processes. Plans were in place to hold both staff and resident/relative meetings following the appointment of the new

home manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not appropriately deployed on the unit for people living with a dementia. This meant people on this unit were not properly protected from harm.

Risk assessments and risk management plans were not always in place. In the case of people on the unit for people living with a dementia, risk management plans did not provide any guidance for staff about how to deal with behaviour which might challenge others.

Systems to ensure the safe handling of medicines were not sufficiently robust.

Recruitment processes needed to be improved to protect people from the risk of unsuitable staff.

Is the service effective?

Good

The service was effective

Staff told us they received the induction, training and support they required to help them deliver effective care.

Staff understood the principles of the Mental Capacity Act (2005). Arrangements were in place to ensure people's rights were protected when they were unable to consent to their care and treatment in the service.

Systems were in place to help ensure people's health and nutritional needs were met. People told us the quality of food was good and they were able to make choices about the meals they ate.

Is the service caring?

Good

The service was caring.

People who were able to express a view told us staff were always kind, caring and respectful of their dignity and privacy. Staff told

us they promoted people's independence as much as possible.

Systems were in place to protect people's confidential information.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although care records were regularly reviewed and updated, there was limited evidence that people who used the service or, where appropriate, their relatives were offered the opportunity to participate in review meetings. Some care records had gaps in information regarding the care and support people required.

A programme of activities was in place throughout the home. However we saw limited evidence that staff on Rowan unit used appropriate distraction techniques or objects available on the unit to promote the well-being of people who used the service. There was also a lack of person-centred individualised activities in place for people who lived on this unit.

Systems were in place for receiving, handling and responding to complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place at the service. The new manager had not yet applied to register with CQC.

We identified a lack of leadership on Cherry and Rowan units. This meant staff were not appropriately directed on how best to ensure people's needs were met and appropriate action had not been taken to address people's changing needs.

Staff told us they generally enjoyed working in the service and considered the leadership in the home had recently improved with the appointment of new managers. We saw that quality assurance processes were in the process of being improved.

Old Gates 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and 16 February 2017. The first day of the inspection was unannounced. We told the provider we would be returning on 16 February 2017 to continue to review the care people received in the service.

The inspection team consisted of two adult social care inspectors 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. The expert had experience of residential care services.

Before the inspection we reviewed the information we held about the service including notifications the provider had sent to us. A notification is information about important events which the provider is required to send us by law. We also contacted the local safeguarding and quality assurance teams and the local clinical commissioning group to gather their views about the service.

During the inspection we spoke with nine people who used the service across all three units and seven visitors. We also spoke with a total of nine staff employed in the service. The staff we spoke with were the manager, the clinical services manager, two unit managers, one registered nurse, two members of care staff, the chef manager and the maintenance person.

We carried out observations in the public areas of the service. We also undertook a Short Observation Framework for Inspection [SOFI] on the unit for people living with a dementia. A SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care records for eight people who used the service and the records relating to the administration of medicines for a total of 23 people, most of whom were cared for on the unit for people living with a dementia. In addition we looked at a range of records relating to how the service was managed;

these included four staff personnel files, training records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

On the first day of the inspection eight of the nine people we spoke with on Cherry and Holly Units told us they felt safe with the care they received. Comments made to us included, "I need a lot of help to get about; I can't do it on my own. The staff do help me the best they can" and "They got me a special bed so I don't get sore as I don't really get out of bed much."

The second day of the inspection was focused on the care people received on Rowan unit which was the unit for people living with a dementia. None of the people on this unit were able to tell us about their experiences so we spent significant periods of time in the communal areas to observe the care and support people received.

During the first 75 minutes of the inspection on this unit we observed three serious incidents in which people visiting or living or working in the unit were hurt. None of these incidents were witnessed by staff employed in the service as, contrary to an agreement reached previously with the local authority, there were no staff located in the lounge area to ensure people were adequately protected. One incident required a member of the inspection team to intervene in order to protect a person who used the service from potential serious harm. We also observed three less serious incidents later during this period in which two jugs of drink were thrown and a person who used the service tried to sit on another person; all of these three incidents were witnessed and dealt with by staff. Following these incidents the manager arranged for both the activity coordinator and the hotel services manager to be based on the unit to help support care staff; we noted this had a positive effect on the behaviour of people who used the service.

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

In order to understand the behaviours of people on the unit we looked at the care records for the two people who had been involved in the most serious incidents. We noted one of these care records contained no useful information for staff to follow in order to ensure the person received safe and appropriate care. Risk assessments lacked detail and staff had failed to update the care records following a previous serious incident in which the person concerned had exhibited aggressive behaviour. This meant people had not been properly protected from known risks.

One staff member told us the second person involved in the incidents had been more unsettled over the previous few days. We therefore checked this person's medication administration record (MAR) charts. We noted the medicine prescribed for the person's mental health condition had not been administered at the correct dose for an undetermined period of time as the MAR chart had been altered to indicate the prescribed dose should only be given once rather than twice a day. We were unable to gain an explanation as to why this change had been made without authorisation from a prescribing health professional. We also noted there were missing signatures for this medicine on two days in the week prior to the inspection. This meant the person's health was at risk as they had not received this medicine as prescribed.

When we looked at the care records for two people on Cherry Unit we noted one person who had been admitted to the unit from out of area in the previous week was documented as being at high risk of falls. A 72 hour care plan had not been completed as required by the provider for all new admissions. There was also no care plan or risk assessment in place in relation to the person's mobility needs or in relation to their assessed risk of choking; the only care plans completed were in relation to the person's communication needs and the support they required for washing and dressing. Staff on Cherry unit were aware that the individual concerned required a Zimmer frame in order to mobilise safely and that this piece of equipment had not been sent with the person on their admission from hospital. We were unable to tell from the records or from discussions with staff what action had been taken in the three days since the person's admission to ensure this necessary equipment was provided to them. Also in the absence of this equipment it was not clear what action staff were taking to help the person mobilise safely around the unit. This was confirmed by our discussions with the person's relative who told us, "He had a Zimmer frame at the other home but they haven't sent that with him for some reason. Nobody seems to know what's going on." We raised these concerns with both the manager and clinical services manager who told us on the second day of the inspection that the person would be receiving an urgent physiotherapy assessment. We were also shown the person's care records which had been appropriately completed to provide information to staff about the care the person required.

We also noted on this person's records that one medicine they were prescribed was recorded as out of stock on 14th February 2017, although the MAR chart showed that a total of 176 tablets had been received on admission. None of the staff we spoke with were able to explain this discrepancy and it was not clear what action had been taken to clarify if this medicine was needed by the person on an on-going basis. In addition the MAR chart had been amended to show that this medicine was to be given twice rather than three times a day. We could not find any authorisation to support this amendment. All of the entries on this person's MAR charts were handwritten and had not been countersigned to confirm their accuracy.

When we looked at remainder of the MAR charts for the people cared for on Rowan unit we noted most were accurately completed. However we noted on 16th February 2017 that one person's MAR chart documented one medicine had been given up to 18th February 2017. Another person's MAR chart had been signed up to 17th February 2017. There was also a missing signature for one medicine for another person on 15th February 2017. These errors meant we could not be certain that people had received all their medicines as prescribed.

When we checked the medication peer reviews which were completed by a member of nursing staff three times a day we saw that none of these errors had been identified. The peer review for 15th February stated there were no missing signatures. We noted the clinical services manager had identified that these peer reviews were not being properly completed; they told us they were in the process of taking action to ensure staff were held to account for these records.

During the inspection on Rowan unit we observed the agency nurse on duty leave the trolley open and unlocked in the lounge as they went to administer a person's medicine; this meant there was a risk people who used the service might be able to access medicines which were not prescribed for them and could cause them harm.

Records we reviewed showed that all staff responsible for administering medicines had received training for this role. In addition a system was in place to monitor the competence of staff to administer medicines safely. The manager was unable to locate the assessments requested for certain staff during the inspection although these records were subsequently sent to us. However we noted one of these assessments was completed after the inspection dates and another was dated 2015; this meant we could not be certain staff

had received an annual assessment of their competence to administer medicines in line with current guidelines.

The lack of appropriate measures in place to ensure people received safe care, including a lack of risk assessment and risk management plans as well as the unsafe handling of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment processes in place. We reviewed the personnel files for four staff employed to work in the service. We noted that all of these files contained an application form, evidence to confirm each individual's identity and a criminal records check called a Disclosure and Barring service check (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. All of the personnel files we reviewed contained at least two references, although there was no reference from the most recent employer for two staff. We also noted that the provider had not undertaken the required additional checks with all previous employers where applicants had worked previously with vulnerable adults or children. In addition it was not clear that the gaps in one person's employment history had been explored during the recruitment process. This meant there was a risk people who used the service were not fully protected from the risk of unsuitable staff.

The lack of robust recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the staffing levels in place throughout the service. The manager told us that a dependency tool was used to ensure sufficient numbers of staff were always on duty. Staff on Cherry Unit told us staffing had improved since a new unit manager had been in post and that most of the time they were able to meet people's needs without delay. However when we spoke with staff on Holly unit they told us there were insufficient numbers of staff on duty at night time. This was because 20 out of the 25 people on this unit required two staff to meet their needs. We were told there were usually only three staff on duty at night. This meant there were occasions when people had to wait to have their needs met. However the manager told us they had checked that day with the unit manager who had advised them that staffing levels on the unit were sufficient to meet people's needs both day and night.

When we asked people who used the service about staffing levels we received conflicting information. Comments people made to us included, "It's smashing living here; I've no complaints whatsoever. The staff are always here if I need anything", "There are usually staff around if I need anything. You only have to ask or pull your cord if you do" and "I have had one fall since I've been here. The staff were very quick to help me but sometimes they can get very busy." We noted that one person on Cherry unit rang their call bell three times in quick succession during the lunchtime period. Although we noted staff responded quickly on each occasion, our conversation with the person concerned showed they did not feel their needs had been met. They told us, "I need changing. I know that they're busy and they've been very good since I've been here but they shouldn't let me get wet."

Policies and procedures were in place to guide staff about how to recognise when people might be at risk of abuse. Staff told us they had completed training in safeguarding adults and were able to tell us of the correct action to take if they witnessed or suspected abuse. A staff member told us, "I would always report anything to my senior or whoever is in charge or if I want to take it further would always let my unit manager or home manager know."

We reviewed the systems in place to help ensure people were protected by the prevention and control of

infection. During the inspection we found most areas of the service were clean. We noted some areas on Rowan unit were malodorous during the inspection although we observed members of the housekeeping team cleaning bedroom and bathroom areas while we were on this unit. None of the people we spoke with during the inspection expressed any concerns regarding the cleanliness of the service. One person commented, "My room is always clean and the cleaner is lovely."

Records we reviewed showed that the equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This helped to ensure the safety and well-being of everybody living, working and visiting the home. We were told that a new call bell system was in the process of being installed in the service.

We saw a business continuity plan was in place for dealing with any emergencies that could arise. Inspection of records showed regular in-house fire safety checks had been carried out to ensure that the fire alarm, emergency lighting and fire extinguishers were in good working order. Personal evacuation plans (PEEPS) had been completed for all people who used the service; these records should help to ensure people receive the support they require in the event of an emergency. Staff had completed fire training and were involved in regular evacuation drills. This should help ensure they knew what action to take in the event of an emergency.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty 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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had a policy which explained to staff what the MCA and DoLS were and guided staff on their responsibilities. The manager demonstrated a good understanding of MCA and DoLS. Records we reviewed showed the necessary applications had been made to the relevant local authority to ensure any restrictions placed individuals who could not consent to their care in Old Gates Care Home were legally authorised. At the time of this inspection 29 applications had been submitted with three being assessed and approved by the local authority.

We saw there were appropriate arrangements in place to record people's capacity to make particular decisions. We saw meetings had taken place with family and professionals as necessary to ensure any decisions made about the care individuals received was in their best interests, including when it was considered necessary to administer medicines covertly (in food or drink without the person's knowledge) to help ensure their health needs were met.

Staff we spoke with demonstrated a good understanding of the MCA. They were able to tell us how they helped people to make their own decisions and gained consent from people who used the service, including recognising facial gestures and other non-verbal communication where people were unable to express their consent verbally. One staff member told us, "They [people who use the service] have a part in their care plan which is about decision making, so we sit down with them and go through a decision they would like to make and offer choice. We speak to family if it is a more complex decision. We talk things through with them. At the end of the day it is their decision, their choice." People on Cherry and Holly units told us staff always asked for their consent before they provided and care; this was confirmed by our observations during the inspection.

We looked to see how staff were supported to develop their knowledge and skills. Records we reviewed showed staff completed a five day induction when they started work at the service. This induction helped to ensure staff had an understanding of their role and how they should support people. The induction included training on topics such as safeguarding, moving and handling, food safety, fire safety, infection control, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), basic life support and health and

safety. We saw that staff were required to complete a knowledge check on each subject area after they had completed the training; this helped to ensure staff fully understood the content of the training. Staff we spoke with told us they had enjoyed the induction and felt it had prepared them well for working at Old Gates. One staff member commented, "It was all sorts of training, examples, scenarios, what would you do, then things were explained and procedures you have to follow. Our induction was really good; I just knew what I was doing because I was given that much knowledge by our trainers."

We saw that there was a programme of refresher training in place. A central record was held by the area trainer to confirm what training staff had completed. At the time of this inspection the central record showed 76.3% of staff had completed all required training. One of the staff we spoke with told us, "We have all sorts of training, moving and handling, fire and when we need to update our training they will put a list up for us to do it."

We asked the manager about the supervision of staff; supervision meetings provide staff with an opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. The manager told us that since they had started at the service they had completed a supervision matrix which had been given to unit managers; this was to be used to record when staff had received supervision. We were told that as yet this process had not been fully rolled out on the units. However most of the staff we spoke with told us they felt well supported in their work and had the opportunity to discuss their learning and development needs with the unit managers. One staff member commented, "I haven't had supervision but I feel that I have had all the training I need."

We looked at the systems in place to ensure people's nutritional needs were met. Seven of the eight care records we reviewed contained a care plan which identified each person's needs and risks in relation to their nutritional intake. Where necessary staff had made referrals to specialist services including dieticians and speech and language therapists (SALT).

People who were able to express a view told us they enjoyed the food provided in the service and that it was of good quality. Comments people made to us included, "'The food here is very good. They bring you a menu each day and you can choose what you want. If you don't fancy anything on the menu, you can ask for something different" and "I do get plenty to eat and they always offer me something different as I don't like sandwiches."

We were told that invitations had been sent out to invite people who used the service and their partners to eat a Valentine's Day meal together the evening before the first day of the inspection. We were told that, although only a small number of people had chosen to participate in the event, all had thoroughly enjoyed the occasion. The chef manager told us that other events such as Chinese New Year and St Patrick's Day were always celebrated with special meals.

During the inspection we observed the lunchtime experience on both Cherry and Rowan units. On Cherry unit we saw that six staff were available to meet the needs of people, with staff providing individual assistance where necessary. On Rowan unit we observed the lunchtime experience lacked organisation although people did receive the support they required to eat their meals.

We saw that drinks were made available to people both at mealtimes and throughout the day. We noted from the menus we reviewed that the lunchtime meal provided was a lighter option as the main meal was served in the evenings. The menu also offered a "Night Bite" option of dishes which staff could prepare in the small kitchenettes located on each unit when the main kitchen was closed.

The catering manager told us they were aware of the likes, dislikes and any allergies people who used the service might have. They told us people were asked about their meal choices on a daily basis and that if they did not want what was on the menu alternatives were always available.

We found the kitchen was clean and well stocked. We saw that checks were carried out to ensure food was stored and prepared at the correct temperatures. The service had received a 5 rating from the national food hygiene rating scheme in January 2016 which meant they followed safe food storage and preparation practices.

We asked staff how they kept up to date with people's changing needs to ensure they provided safe and effective care. All the staff told us they attended handover meetings at the start of each shift although we could not find a record of all the recent handovers which had taken place on Cherry unit. Staff told us that all important information was also recorded in the diary held on each unit so that staff could refer to this throughout their shifts.

People who used the service had access to healthcare services and received on-going healthcare support. Care records contained evidence of visits from district nurses, GPs, speech and language therapists, dieticians and mental health professionals.

Good

Is the service caring?

Our findings

All the people we spoke with on Holly and Cherry Units told us they found staff to be caring, kind and respectful. Comments people made included, "The staff are very good, very pleasant", "Oh they're very good. Very caring yes" and "The staff are very good with [name of relative]. They always speak nicely to her and make us feel really welcome when we visit."

It was not possible to ask people on Rowan unit their opinion of staff. We therefore undertook observations in the communal area of the unit. During these observations we found care staff had limited interaction with people who lived on the unit. However on the same unit we also noted positive interactions between the hostess, activity coordinator and housekeeper and people who used the service.

During the inspection we noted visitors were welcomed in to the service. People who used the service were able to meet with their visitors in the communal areas or in their own room if they preferred. Relatives we spoke with on Rowan unit told us they had always found staff to be kind and caring whenever they visited their family member.

Where appropriate, we saw that staff knocked and waited for an answer before entering bathrooms, toilets and people's bedrooms; this was to ensure people had their privacy and dignity respected.

People who used the service on Cherry and Holly units told us staff always tried to promote their independence as much as possible. On Rowan unit we saw that a member of housekeeping staff encouraged a person who used the service to help them make a bed and brush the floor in a bedroom. They told us this helped to keep the person occupied and reduced their anxiety levels.

Care records were organised into a number of sections including a pen picture ('My Day, My Life, My Portrait') of each individual, their likes/dislikes and their family and social history. This should help staff form meaningful and caring relationships with the people they supported. Care plans also included information for staff about how they should promote people's independence wherever possible.

Records we reviewed included a 'Future Decisions' section; this contained information about the care and support people wished to receive at the end of their life. Some staff had completed training in end of life care to help ensure they were able to provide the best care possible at this important time.

We noted that Information was on display on all the units regarding the advocacy service people were able to contact should they want independent advice or support.

We noted that all care records were held securely; this helped to ensure that the confidentiality of people who used the service was maintained.

Requires Improvement

Is the service responsive?

Our findings

Arrangements were in place for the manager or another senior member of staff to assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Where relevant information was also obtained from other health and social care professionals such as the person's social worker. This process should help to ensure that people's individual needs could be met at the home.

We were told by the clinical services manager that the resident of the day system was now being more robustly implemented in the home; this process was meant to ensure that a person's care records were reviewed and updated and that they were asked to provide feedback on the care and support they received. Records we reviewed showed that care records had been reviewed and updated although some gaps in information had been identified by the clinical services manager during their audit of the records. In addition we could not find any evidence that individuals or, where appropriate, their relatives had been involved in the review process. The unit manager on Holly unit showed us letters they had sent to families inviting them to attend reviews but told us there had been limited uptake in the process. None of the relatives we spoke with during the inspection had any major concerns about the care and treatment their family members received.

Following the inspection, due to the numbers of incidents we had witnessed on Rowan unit, we asked the manager to send us copies of risk assessments for three people; this was so that we could ensure they had been updated and contained sufficient information to guide staff about the best way to support the individuals concerned. Although all risk assessments had been updated, we noted that one person had stated during the review of their risk assessment following the inspection that they did not feel their cultural needs were being met at Old Gates. It was recorded that they did not like the food provided to them and had no opportunity to express their religious beliefs. The manager told us the person had been admitted prior to them commencing employment at the home and advised they had arranged an urgent review of the person's placement. It is important that services properly consider whether they are able to meet people's spiritual, religious and cultural needs prior to accepting their placement in the home.

During the inspection we observed good practice as a care staff member spent time with a person on Cherry unit asking them about the care they received and whether it was appropriate for their needs. We also noted from the records we reviewed that this same staff member had spent time with a person recently admitted to the unit as they had identified the individual was feeling low in mood. They had documented information they had found out about the person's life history and interests and had passed this on to the activities coordinator so that this could be incorporated into 1-1 activities with the person; this demonstrated how the service was responsive to the person's emotional needs.

We looked at the activities available to promote the well-being of people living in the home. We noted there was a plan in place to hold at least one organised activity on each unit during the week. We were told it was recognised that this needed to be extended to include weekends. An activity coordinator had also been

appointed to work on full time basis on Rowan unit although they had not yet commenced employment at the home.

During the inspection we saw there were a number of objects on Rowan unit which could be used to help engage or distract people should they become distressed or exhibit behaviour which might challenge others. However, we did not see any of these objects being used in a meaningful way with people during the course of our inspection on this unit and we noted most staff failed to engage with people other than in a task focused manner. Following the serious incidents we observed on this unit the manager deployed additional staff to interact with people. We therefore noted the activity coordinator and the hotel services manager encouraged people to participate in a bingo session and supported individuals to engage in 1-1 discussions about past events, art and nail care activities. Although this had a positive impact on the behaviour of people who lived on this unit, there was a general lack of planned, individualised and person centred interventions for people who lived with a dementia. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People on Cherry and Holly units told us they were generally satisfied with the range of activities available to them. Comments people made to us included, "There's lots to do here. We even had a pantomime the other week but it isn't for me that sort of thing", "We had a singer in last night. He was very good. He did lots of different songs that we all knew", "I like the bingo. I'm actually quite lucky at the bingo as well although the prizes aren't all that good" and "We do some gentle exercises each week. It just helps us to keep fit."

We reviewed the systems for managing complaints received in the service. A copy of the complaints procedure was displayed in the reception area and was included in the service user guide. People who used the service and their relatives told us they would feel confident to approach staff on the units if they wished to make a complaint. Comments people made to us included, "If I had a suggestion or something I felt I had to complain about I could just speak to a member of staff; they always listen", "I've never had any complaints. I like to keep myself to myself. I could always talk to the manager though if I did I suppose. You see them sometimes" and "'I can talk to staff if I'm worried about anything and they always explain everything."

We looked at the log of complaints held at the service and saw that the manager had responded to complaints which had been received prior to their employment at the service. They told us it had taken a significant amount of time to gather the required information in order to be able to respond appropriately. All complaints were recorded and monitored centrally by the provider so that themes and trends could be analysed.

Requires Improvement

Is the service well-led?

Our findings

Although the service had a new manager in place they had not yet applied to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was supported in the running of the service by a newly appointed clinical services manager and three unit managers.

The manager told us that since their appointment they had concentrated on responding to a number of complaints which had been received at the service before they commenced employment. In addition they had appointed a number of new staff including a full-time activity coordinator who would be based on Rowan unit once they started work at the service.

During this inspection we found there was a lack of leadership on both Rowan and Cherry units. Staff on Rowan unit had not been given clear direction about the way they should support people whose behaviour might challenge others. They had also not been given clear instructions about particular roles which needed to be undertaken, including who was responsible for monitoring the communal lounge/dining area throughout the day; this had resulted in some of the incidents we witnessed during the second day of the inspection. In addition we found that changes in people's behaviour had not always triggered a review of relevant risk assessments and risk management plans; this meant staff did not always have up to date information about the best way to respond to people's needs.

Staff on Cherry unit were not coordinated in the way they responded to the needs of a person who had been recently been admitted. Communication between the staff team was fragmented which meant it was not clear who, if anyone, was taking responsibility to ensure the person's needs were properly assessed and met.

The manager told us they had recognised that the managers in post on both of these units required additional support and monitoring in order to ensure they were able to provide effective leadership. However it was not clear what action had been taken to ensure the required support was provided.

The lack of effective leadership in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the first day of the inspection we observed the daily 'Take 10' meeting. This was a meeting between the manager and senior staff from all departments which was used to check on issues including staffing, customer feedback, resident of the day reviews and planned activities.

We noted the newly appointed clinical services manager had begun to complete audits of care records and had given clear instructions to senior staff about how records needed to be improved. We saw that the clinical services manager had taken action to ensure all identified shortfalls in a person's records had been

rectified within the required timescale.

Staff we spoke with during the inspection told us they generally enjoyed working in the service. They told us they considered the leadership in the service had improved since the new manager and clinical services manager had been appointed. Comments staff made to us included, "I go to [name of manager] with any concerns; she is really good", "[Name of manager] always has time to talk to you. You can say what you want and feel comfortable in raising issues" and "[Name of clinical services manager] is lovely; I think she will be really good."

There had been no staff meetings at the service since the change of provider which had taken place only two weeks before this inspection. The manager and staff team had remained the same following the change in provider. Staff told us they had confidence that their views would be listened to by the managers in the service.

The manager told us since they started at the service they had timetabled a series of resident/relatives meetings throughout the year; information about these meetings was clearly displayed in the home; the first of these meetings was due to take place shortly after our inspection.

Most people we spoke with during the inspection were aware that a new manager was in post although not all had had the opportunity to meet with them. Comments people made to us included, "I see the manager about sometimes but I've never really felt like I need to talk to her about anything" and "I'm not sure who the new manager is now. I know they've got a new one but I haven't met her yet."

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 There was a lack of personalised and individualised activities for people living with a dementia.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risk assessments and risk management plans were always in place and accurately reflected the needs of people who used the service and the support they required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not taken proper steps to ensure the leadership throughout the service was effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment process in the service needed to be improved in order to properly protect people from the risk of unsuitable staff.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not taken proper steps to ensure staff were appropriately deployed in the service. This placed people at risk of receiving unsafe care.