HC-One Oval Limited

Stadium Court Care Home

Inspection report

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Date of inspection visit:
23 July 2018
24 July 2018
25 July 2018

Date of publication:
03 September 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 23, 24 and 25 July 2018, and was unannounced. Stadium Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Stadium Court Care Home is registered to provide personal care and accommodate up to 110 people in five adapted buildings. However, only three buildings were currently occupied. These three buildings, or 'units' were called Stafford, Spode and Wade. There were 77 people using the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. This registered manager was only planning on being there temporarily until a permanent manager was recruited. There were also unit managers for each unit who reported to the registered manager.

This is the homes first ratings inspection since it was registered.

At this inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of this report.

We have made a recommendation that arrangements for staff with a positive Disclosure and Barring Service (DBS) check are reviewed to reflect current working arrangements.

We have also made a recommendation that people's care plans contain more personalised information.

Medicines were not always being managed or stored safely. We could not always be sure that people were receiving their medicines as prescribed.

Quality assurance systems in place did not always ensure that people received a safe and effective service. However, some improvements required had been identified and an action plan was in place that was in progress. People felt able to approach the registered manager or unit managers. However, there was some confusion from people, relatives and staff about the management structure and ongoing changes. People and relatives were asked for their opinion about care but some felt that communication could be improved.

There was mixed feedback about staffing levels and work was ongoing to improve staff deployment. People told us they felt safe but risks were not always assessed, planned for and managed appropriately. People were protected from potential abuse by staff who understood their safeguarding responsibilities. People were also protected from the risk of infection as the home was clean and tidy and systems were in place for

infection control. The building was appropriately maintained and plans were in place in case of emergency.

People were not always supported to maintain their dignity. However, people felt staff were kind and caring. People were encouraged to be independent and there were no restrictions on people visiting the home.

We found that some staff had not always received refresher training relevant to their role. However, the provider was in the process of addressing this, to ensure staff had the appropriate skills to meet people's needs. People's human rights were protected because staff were aware of the principles of the Mental Capacity Act 2005, which was adopted in their care practices. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People were supported to have food and drinks of their choice. People had access to other health professionals to ensure their physical and mental health. The building was suitably adapted to cater for the people living in the home.

Complaints were recorded, investigated and responded. However prompt action was not always taken to ensure improvements were made with regards to concerns raised. People and relatives told us that they were involved in developing their care plan. People were supported to communicate and plans were in place to guide staff on how people communicated. Plans were also in place when people were nearing the end of their life to ensure their choices were respected. There were a range of social activities available for people to partake in and people could pursue their interests.

Other professionals who work with the home felt it worked well with their organisations and they noted many improvements had been made. Notifications were submitted as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not always safely managed.

There was mixed feedback about staffing and improvements were needed to ensure staff were deployed effectively.

Risks were not always appropriately managed and this placed people at risk of potential harm.

Where things had gone wrong the provider had taken relevant action to avoid this happening again.

People felt safe and action had been taken if there was suspected abuse.

Plans were in place to support people in the event of an emergency and the building was safely maintained.

Is the service effective?

Good

The service was effective.

Staff did not always have their training refreshed to ensure they had the skills to meet people's needs. However, the provider had taken action to address this.

Staff felt supported by the managers to carry out their role.

People were being protected as the principles of the Mental Capacity Act were being adhered to.

People had access to sufficient food and drinks of their choice and suitable for their needs.

People were supported to remain healthy with access to other health professionals.

The building was suitably adapted to support the needs of people living there.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Practices did not always ensure that everyone's dignity was maintained.

People were supported by staff who were kind and caring and who encouraged them to be independent.

There were no restrictions on visiting times. People were able to personalise their bedroom to reflect their preference.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints were recorded, investigated and responded to however timely action was not always taken to ensure improvements identified from a complaint were resolved.

People and relatives felt staff knew them well and felt involved in their care however more personalised detail would be beneficial in some care plans.

People were supported to partake in a range of activities.

People were supported to plan for the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems in place were not always effective in assessing, monitoring and driving improvements.

People, relatives and staff felt they could go to the registered manager but there was confusion about the management structure and changes taking place.

An action plan was in place to try and improve the service.

People and relatives were asked for feedback about their care.

Other professionals felt the service worked well with their organisations.

Stadium Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 23, 24 and 25 July 2018, and was unannounced. The inspection was carried out by three inspectors, two medicines inspectors and three Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners if they had any information they wanted to share with us about the service.

We spoke with 11 people who used the service and 17 relatives. We also spoke with 13 members of staff and two visiting healthcare professionals. In addition to this we spoke with the registered manager, deputy manager, clinical lead, two housekeepers, one laundry assistant, a maintenance worker, two activity coordinators and other management staff involved in supporting the home. We also had feedback from two social care professionals. We made observations in communal areas. We reviewed the care plans for 15 people who use the service, as well as medicine records for 14 people. We looked at management records such as quality audits and the ways in which the provider monitored the home. We also looked at recruitment files for five members of staff.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. We looked at how medicines were managed by checking the Medicine Administration Records (MAR) for 14 people, speaking with staff and observing how medicines were administered to people. We found the MARs were not always able to demonstrate people were getting their medicines as prescribed. This meant people were at risk of experiencing symptoms of their health conditions.

Some people who had been prescribed medicines on a 'when required' basis had records that had insufficient information to inform the staff of how and when to administer these medicines. For example, the information available to staff directed them to administer anti-anxiety medicines to people when they were anxious and agitated. There was no detail describing how these states were exhibited by individuals and when it was best for staff to intervene for the protection of that person. Staff we spoke with were not aware of when it was appropriate to administer different PRN medicines to help people feel less anxious. This meant there was a risk of people not always having their medicines at the time they needed them.

The temperature of the refrigerators that were used to store medicines was being monitored. The temperature records for all three units showed that medicines in the refrigerators were not being stored at the correct temperature. The temperature records on Wade unit and Stafford unit showed the temperature had dropped below the minimum temperature of two degree Celsius on several occasions. We found some temperature sensitive medicines called insulin that had been exposed to these low temperatures were still present in the refrigerator. Exposure to low temperatures may affect the efficacy of the insulin. Therefore, appropriate action had not been taken to ensure people received medicines that would effectively treat their condition. This put people who received insulin at risk of experiencing symptoms of their condition and becoming unwell.

When people had to have their medicines administered by disguising them in either food or drink the provider had ensured this process was carried out with their best interests in mind. However, we found the provider was not able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. When we asked the unit manager about whether a pharmacist had sent evidence of agreement to this covert medicine and procedures they said, "They haven't actually" and went on to say, "I'm not sure when it was last reviewed." We also found that there was no written information to inform the staff of how to carry out covert administration process safely and consistently. This meant there was a risk of people not be given their medicines in line with guidance which could change how effective or safe the medicine is.

We also found where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary information was in place to ensure that these medicines were prepared and administered safely. We spoke with one of the nurses about how they had carried out this procedure and found they were not following best practice which could put the person at risk.

One person told us that they were not always supported to have creams applied to their legs. When we checked the Topical Medication Administration Records (TMAR) we found there were gaps in recording which confirmed what the person told us. We also saw gaps in recording on other people's records too. This meant people could not be confident that they would receive their treatment as directed by the prescriber and this placed their health at risk.

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

Despite this, some people told us they felt appropriately supported with their medicines. One person said, "My medicines are given to me on time and I can take them myself but they do help sometimes." Another person said, "The staff are good with my medicines. They make sure I take them. There are no problems." One relative said, "They do all [person's name] medication. I have seen them done and this is all ok." Another relative told us, "Staff do their medicines but sometimes my relative says 'No' to them, so I either encourage my relative but if we're not lucky enough the carer will say 'OK I will come back later ' which they do. So, they always get them [medicines] in the end." Another relative commented, "Staff do the medicines for my relative and do them well."

We looked at how Controlled Drugs were managed. Controlled Drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found the Controlled Drugs were stored correctly and their administration was recorded accurately showing that these medicines were administered as prescribed. We found the analgesic skin patches were changed at the prescribed time intervals and were applied to different parts of the body so that people did not experience unnecessary side effects.

People could not be assured that they would be supported by effectively deployed staff. There was mixed feedback regarding staffing levels. Comments included, "I can wait ages for the loo [toilet]" and another person said, "[Waiting times] are pretty good but [staff] could be faster." When the person made this comment, they were with one of the inspection team and they had to wait at least 15 minutes for a response after they pressed their buzzer. A relative said, "I'm still concerned about staffing levels" and they went on to say, "They count nurses as part of the team [but they don't carry out carer duties]." Another relative said, "Staff are rushing around and not able to respond to buzzers" and, "The staff levels are too low." The same relative also specifically fed back about particular times of day when some hours were covered by less staff in an evening, which were confirmed by some of the rotas we looked at. One member of staff told us, "Some days we have enough but the [staff] numbers can drop. It can be chaotic some mornings." Another member of staff said, "We have some people who need more attention so we're constantly playing catch up." We observed incidents in the Stafford Unit between people where staff were not present, so were unable to intervene. In other units our observations sowed that people were supported by sufficient numbers of staff. In Stafford unit, for example, one person was being verbally aggressive to another and was swearing at the other person. The other person reacted by approaching the person, although the situation rectified itself. In another incident, another person shouted an insult at another person and staff were not directly in the area to intervene. We saw it documented in some records that one person did not always have their one-to-one support as there were not always enough staff and some audits carried out within each unit had identified staffing was sometimes short. We saw that staff had raised issues about staffing and the skill mix of staff during meetings and the provider was taking action to try and resolve this. A member of the management team would check with all units at the start of each day to check that staff had attended their shift and whether there were any staff shortages. If there was staff absence, the management would try to arrange cover with internal staff or arranging agency staff to attend. The provider was already developing a dependency tool in order to effectively monitor and decide upon staffing levels; however, this was not yet in

place. This will be checked during our next visit to the home.

We saw that staff were recruited safely and to ensure they were of a suitable character to support people who used the service. Staff were subject to pre-employment checks such as getting two references, identity checks and checking with the Disclosure and Barring Service (DBS) whether they had any criminal convictions. We saw that if a staff member had a conviction on their DBS then this had been considered by the provider. However, these had not always been reviewed to reflect current arrangements in the home. We recommend that these are reviewed so they reflect current working arrangements and ensure people were protected by continuing measures in place.

Risks were not consistently assessed, planned for and guidance followed. We found some plans contained good detail and guidance for staff about how to safely support people. However, we found that risks had not always been consistently assessed, planned for and that staff were not always following guidance. For example, one person had a plan in place as they slipped out of their specialist chair on numerous occasions. This plan said the person should be sitting on a non-slip mat whilst sitting in their chair to try and help them stop slipping out. However, during our inspection, we observed the person was not sitting on the non-slip mat and the staff member we spoke to about it said, "No, I don't think they are." The person had recently had another slip from their chair. This meant the person was at risk of getting an injury as staff were not always following the risk assessment to keep the person safe. An unaccompanied contractor was installing another radiator in one of the units and tools were in the corridor. When we asked them what risk assessments were in place to keep people safe they did not know. This meant they were not following any assessments that may have been put in place and the provider had failed to ensure that contractors on site were aware of any necessary information to keep people safe. This meant insufficient plans had been put in place and risks were not always assessed.
Despite this, some people told us they felt safe living in the home. One person said, "I do feel safe here, the staff are good." A relative told us, "My relative had a lot of falls when they first came here but none of late so yes, safe overall."

People told us they felt safe and people were protected from potential abuse. One relative said, "My relative is as safe as they can be." Another relative said, "It's absolutely great here. I wouldn't let [person's name] stay here if it wasn't." The registered manager told us, "We need to make some decisions, in order that resident and staff safety is maintained." A visiting health professional told us, "I would have no hesitation in having a relative living here and I would come and live here myself." Staff knew about the different types of abuse, how to recognise the signs of potential abuse and staff understood their safeguarding responsibilities. We saw appropriate referrals had been made and action had been taken to protect people.

We observed two instances where people were not supported to move safely. In one example, a member of staff supported a person to stand and then sit in a wheelchair without using their frame when they were assessed as needing a frame and we could see the person was unsteady and was not able to sit safely on the seat of the wheelchair. The member of staff then wheeled the person to the toilet and did not take their frame and they did not have support from another member of staff. We reported this to the unit manager who took immediate action to ensure the person was supported safely and the member of staff was supported to re-train within a day of our feedback. This meant that despite occasional instances of unsafe moving and handling, feedback was acted upon swiftly to reduce the likelihood of a reoccurrence and lessons were learned. However, the majority of moving and handling observed was done safely. People told us they were supported to move safely and some relatives confirmed people were supported. One person said, "I do need help to get up, I can't get up myself but staff have things [equipment] they help me with." One relative said, "My relative cannot walk and needs to use a wheelchair to get around. Staff are fine at making sure they are moved safely." We saw other examples of lessons being learned as action was taken if

there had been medicines errors identified to protect people and to try and prevent it happening again.

People were protected from the risk of cross infection as appropriate measures were in place. Relatives said, "Yes they do wear gloves and aprons" and, "Yes they wear gloves." Another relative said, "They always wear gloves when doing them [giving medicines]." We observed that staff had been provided with personal protective equipment (PPE) gloves and aprons. The appropriate use of PPE helps to reduce the risk of cross infection. The home was equipped throughout with hand washing facilities, which promoted regular hand washing. Bathrooms and corridors were clean and there were no malodours in all rooms we entered, including some people's bedrooms. There were also signs in appropriate places giving guidance about hand washing. This ensured infection control procedures were followed to help keep people safe.

The building was being appropriately maintained with checks being completed on the electrical and gas systems and water systems were flushed and checked sufficiently. Checks were also carried out on equipment being used by people to ensure it was safe. We saw that plans were in place for people if they needed to leave the building in an emergency, called a Personal Emergency Evacuation Plan (PEEP). This meant people were being kept safe in suitable building and plans were in place should an incident occur.

Good

Is the service effective?

Our findings

People and relatives gave us positive feedback about staff ability to support them. One person commented that they felt staff were, "Reasonably well trained." One relative felt positively and said, "Their training is fine they can do better than me!" Staff told us they received training; one staff member said, "The training is pretty good here." Another said, "If there is a course going, we will go." We saw records that multiple staff had not received updated training recently in some areas. However, plans were already in place by the provider to ensure staff training was updated and a new training system had recently been launched. This meant training could have been improved but steps were already in place to address this.

Staff generally felt supported in their role. One staff member said, "I am supervised by one of the nurses, every three months." Another staff member said, "I find supervisions very helpful, you learn a lot. Mostly positive feedback." This demonstrated that staff were supported in their role to ensure they knew how to meet people's needs.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that decision-specific assessments had been carried out to determine people's capacity and when it had been determined that someone did not have capacity, a best interest decision had been considered and documented and were the least restrictive as possible. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions on behalf of someone who has lost their capacity to make their own decisions. We saw that the service had copies of the LPOA available for people who had one in place.

Staff understood the MCA when we spoke with them and we saw staff offering choices. One person told us, "The staff don't start anything without asking me first and talking me through it." A relative said, "The staff do [check consent] actually yes, and my relative will say yes or no to things to the staff. My relative does understand even though they have dementia." Another relative told us, "My relative can't converse and will just smile to anything. When I have been here the staff have asked her though [before supporting my relative]." A member of staff said, "Always give a person choices; what to wear, what to eat. People are asked earlier what they want for their meal, but then at the mealtime they are still given a choice." We also observed this in practice. This meant people were being supported in line with the MCA.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that appropriate referrals had been made and people were not being unlawfully restricted.

People told us and we observed they had a choice of food and drinks and were supported to have sufficient amounts to eat and drink. People and relatives confirmed people were supported to eat food appropriate to

their needs. One person said, "I can eat by myself, they [staff] bring it to me." One relative said, "Yes my relative has to have soft foods and it needs to be ground down. They [staff] are feeding my relative at the moment." Another relative commented, "I help at mealtimes. My relative needs feeding as they can't do it themselves. When I am not here they [staff] will sit with my relative and do it." We observed people with meals that were the right consistency to help reduce the risk of them choking. We observed staff assisting people to make choices about their food and if a person was being assisted to eat they were not rushed by staff. We also observed staff encouraging people to eat more of their lunch if they were able to eat independently and people were able to have more if they wanted it. People were offered hot or cold drinks throughout the day and ice creams, as it was very hot. If people needed to have food that was soft or pureed due to their health condition, we saw staff giving people food of the correct consistency.

People were supported to try and remain healthy as they had access to other health professionals and plans were in place to guide staff. One person said, "Yes, they do arrange for professionals to visit." Another person told us an optician had been to see them recently and they were getting new glasses. One relative said, "The home make appointments as required but if we ask for anyone they will see to it for my relative." Another relative said, "My relative has the doctor come if needed." Two other relatives told us about access to GP services as a GP held a surgery on site one day a week. The relatives also said that in an emergency a doctor would be called out of hours if needed. A visiting GP told us, "I visit on a weekly basis and go into each unit. I have found the staff to be approachable, helpful and professional." One other visiting professional said, "I visit the three units, every week. Things have improved. I previously had some concerns but I am really impressed now. The staff all phone if there are any issues." Another professional comment included, "Staff are very good with contacting GP's and the nurses are really good" and, "The staff are very good and respond to me effectively." We saw some people had diabetes and were supported by staff to check their blood sugar levels and there was a detailed plan in place which identified people's ideal range for blood sugar readings and what action to take if they were outside of this range. This meant people were supported to remain as healthy as possible.

The building was suitably adapted for the people living there. It was all on one level to allow ease of access and corridors were wide and well-lit with grab rails for people to use if necessary. There were specially-adapted bathrooms to provide easy access for bathing, showering and using the toilet. In Stafford unit where many people were living with dementia, there was appropriate signage and personalised information outside of their bedrooms to help them to orientate themselves and find where they wanted to go. Specialist equipment was available for people to use if they required it; for example, hoists, frames, padded mats to protect people if they fell and wheelchairs.

Requires Improvement

Is the service caring?

Our findings

Some people and relatives reported that some staff could be abrupt in their approach and were not always caring and did not always ensure people were treated with dignity. One person, "They don't cover me up, but I don't mind." One relative said, "They're [staff] pretty good but some people can be a bit sharp." Another relative said, "They would rather chat to each other than work." Another relative said, "Some are very good, but some are short tempered, they think they know her well, but they don't always listen." Two relatives told us about how some people could require more staff time than other due to their needs and behaviours. These relatives felt that other people then 'lost out' and one relative said, "Those [people] who shout loudest get the most attention." We observed a person stand up whose trousers were undone and were falling down. Staff went to support the person to sit back down however they did not help the person to fasten their trousers. The person stood up again and their trousers then fell down in a communal area with others around. Staff again led the person to another chair but did not support the person to change their trousers or secure them so there was the potential for their trousers to fall down again in front of other people. This meant the person was left in an undignified situation and they were not supported by staff to maintain their dignity.

We saw in a recent relative's survey, responses had identified that improvements were needed in the support people received to maintain dignity. We also saw that staff conduct had been discussed at a recent staff meeting and some staff had raised concerns about the way some staff spoke to people. This meant concerns had been raised to management which were being dealt with, however further improvements were required to ensure improvements were made an embedded so people were always treated with dignity and staff conduct was caring.

A relative we spoke with told us their relative's clothing would sometimes go missing or another person's clothing would be in their relative's room. They said, "Things do go missing over a course of a year like my relative's clothing. I have opened the wardrobe and found ladies underwear and clothes in it. There just seems to be a lack of respect for people's property." We spoke with the staff who worked in the laundry. One laundry staff member said, "We have a lot of problems [with getting the right clothes to people]" but they explained that a new machine was to be used shortly to be able to mark clothes temporarily so that labels could be removed from clothing once someone leaves the home. This meant some issues had occurred but plans were being implemented to try and resolve this.

Despite some issues, some people and relatives reported that most staff were kind and caring. One person said, "Yes they are nice and friendly and caring to me and do come and chat to me. They look after me well." Comments included, "They're [staff] not too bad. I can't complain. I appreciate the care from the nurses, they look after us so well… they are respectful and generally very kind." A relative said, "Yes the staff here are nice and do their best to give my relative nice care." Another relative said, "Very caring, very friendly and always make time to talk to my relative." Other comments from relatives included, "From the short time my relative has been here they [staff] all seem very nice and all the staff are good to my relative," "The staff are caring," "Yes, very much so and their personalities make my relative's day" and, "The staff are all caring and polite." Comments from other health professionals included, "The staff appear to be caring and supportive

to the residents" and, "Residents get positive caring support. I would definitely be happy with a parent of mine living here."

We were given an example of how staff had gone above and beyond in the support of a relative. A relative told us, "I was not feeling well and phoned them to say I could not come in. I then collapsed. The staff that had taken my call thought I was not sounding good so sent around some staff. They could see I wasn't well and came in and called the ambulance for me. How good was that of them all?"

People were supported to be independent and have choice and control over their care. One person said, "They do ask me to do what I can and I am capable a bit." One relative said, "Staff are always encouraging my relative to try to do things for themselves; as much as they are able to." Another relative said, "Staff do try, as well as me, to encourage my relative and get them engaged." One relative said, "Since [my relative has moved] here I do have control over things better." People could choose where to spend their time and could personalise their own rooms. One person showed us a bird feeder outside of their bedroom window which they greatly enjoyed. One relative commented that they felt their relative's room was 'nice, bright and well-cleaned.'

We asked people and relatives if there were any restrictions on visiting times. One person said, "My family visit often and are made welcome." All relatives we spoke with told us they could visit people at any time they liked. Comments included, "We can come to see my relative at any time," "I pop in whenever I can," "There are no restrictions" and, "No restrictions whatsoever." One relative did comment, "We are asked not to come in at meal times because any distraction would put my relative off eating." This meant relatives could visit at a time convenient for them except when it may negatively impact upon their relatives.

Requires Improvement

Is the service responsive?

Our findings

People and relatives felt able to make a complaint and knew how to. However, timely action was not always taken following a complaint being investigated. One person said to us, "I spoke to the Unit Manager. I felt that this complaint was not sorted out and I was not listened to." We saw in a recent relative's survey that relatives did not always feel satisfied with the response they received. We saw a complaint had been received, investigated and responded to in February 2018, and the response sent to the complainant was that some staff would receive some specific training to avoid further issues occurring. We found that this training had not taken place in a reasonable amount of time. When we spoke with a manager about this they told us it would be resolved immediately. This meant the provider recorded and responded to complaints but timely action was not always taken to improve people's care.

People and relatives were involved in people's care; however further work was required to ensure care plans were personalised. We saw that plans were in place to guide staff to support people with basic details however some plans contained limited personalised detail and were very clinically-orientated. One member of staff said, "Plans are a bit basic. We can't put enough information in that's person-centred. We'd like it to be more personalised as everyone has the same thing." We recommend that plans consistently contain more personalised information to ensure staff know people's life history to facilitate more individualised care.
A relative said, "I work very closely with the carers here and we have developed a very good working relationship. We help each other [relative and staff]." Another relative said, "My relative certainly does [have a care plan]. The staff keep it up to date and any changes are noted and put into it. I can view it any time I want to." Another relative said, "Yes my relative had one [a care plan] put together when they came here a few months ago." One relative said, "I have full input what with being here all the time." Another relative commented, "Yes I am involved as required as they are my relative." Another relative told us, "I attend reviews when I can, if not they let me know everything." Another comment was, "The staff keep us informed and update us with any changes in my relative's care plan and let us know of any health problems."
Relatives felt their loved ones were well looked after. One relative said, "The staff have been absolutely magnificent, they look after me as well." Another relative commented, "They have settled him in well and getting to know him well with what he likes and doesn't." A visitor said, "I am very pleased with the care [person's name] gets." We saw that plans were in place to guide staff to support people with basic details however some plans contained limited personalised detail and were very clinically-orientated. One member of staff said, "Plans are a bit basic. We can't put enough information in that's person-centred. We'd like it to be more personalised as everyone has the same thing." We recommend that plans consistently contain more personalised information to ensure staff know people's life history to facilitate more individualised care.

If people were nearing the end of life we saw plans were put in place to support them. A local organisation which specialised in supporting people at the end of their life had been involved in developing palliative care plans. We also saw a section of a plan called 'My Final Days' which included particular wishes and religious needs.

People were supported to communicate. One relative said, "They are always talking to her and motivate her. They keep talking to her and her vocabulary is coming back slowly and they knew she needed help with this and I have seen the improvement." We saw people had communication plans in place which helped staff to understand how best to communicate with people.

People were supported to partake in activities and their interests. There was a 'tuck shop' regularly available that people could visit which was run by relatives. One person said, "I join in activities and do competitions. I like doing that" and they went on to say, "I like the competitions and the activities they put in. I like the singers and music, there is one on today." Another person commented, "The activities are good." Another person told us they preferred to stay in their room but they enjoyed watching TV and could read the paper and magazines but they would occasionally visit the lounge. One relative told us, "The atmosphere here is good, it's got a buzz." A relative told us, "They take my relative out into the garden." Another relative told us, "Staff converse with my relative but due to my relative's current condition they can't join in but can go and listen in to things." Another relative said, "Staff do their best to keep my relative cheerful and they are going outside to the singer and BBQ that they are doing today. My relative likes listening to songs but is restricted in what can be done for them." Other comments included, "My relative likes the television and doing as much as they can with activities. Today there is a singer on outside and I will take my relative there and they will enjoy that as they like music." Another comment was, "My relative likes TV and flower arranging which they [staff] do with her. They also like to go out into the gardens and listen to activities like singers, when they are on. There is one here later on this afternoon." We observed there was a pre-arranged singer and a BBQ party on the second day of our inspection. We saw people and relatives spending time outside and saw people enjoying themselves and the staff were joining in. One person told us, the event was "very good." We observed people partake in flower arranging, walks around the grounds and staff using reminiscence cards. This meant people were supported to partake in activities and pursue their interests where possible.

Requires Improvement

Is the service well-led?

Our findings

We saw an action plan was put in place when the provider took over the home. We saw some improvements had been made and some improvements were ongoing. However, some systems in place were not always effective at identifying concerns and necessary improvements. For example, there was a 'Resident of the Day' scheme in place per unit whereby all aspects of support for a particular person was reviewed. However, these reviews had failed to identify when some information was missing such as protocols in relation to medicines for a person who had them via Percutaneous endoscopic gastrostomy (PEG). PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into the person's stomach through the abdominal wall, most commonly to provide means of feeding when oral intake is not possible. There was a lack of agreement from other healthcare professionals and some plans lacked detail. Qualitative reviews about the care people were getting were also not always effective. The registered manager and other senior staff would complete walk arounds of units to ensure the environments was suitable and to review the quality of care. However, these had failed to identify that some staff were failing to follow risk assessments and that people were not always receiving care in a dignified way. This showed that systems had not become fully embedded and action was not always taken to ensure the care people received was consistently being improved.

Wider audits, which focussed on particular areas, rather than specific people, had failed to identify other areas for improvement, such as medicines storage and some poor recording, particularly for topical medicines. We also saw that staff involved in administering medicines had received updated training. However, they had not had their competency checked since the provider had taken over. which meant the provider could not be assured they were following their training and best practice. The registered manager explained that a new medicines audit was being introduced that month which should improve the efficacy of the quality assurance process, but it had not yet been implemented and improvements not yet sustained. A provider audit had identified some need for improvement. For example, one recent audit had noted that actions had not yet been taken in relation to a medicines audit and other areas for improvement such as engagement with people, relatives and staff. We saw on the action plan and were told that people's dependency levels were in the process of being reviewed to help establish a tool to establish staffing levels going forwards. This was still in progress so we could not yet assess the effectiveness of this. Therefore, some concerns were being identified but improvements were not yet sufficiently embedded.

The home was split into three units. There was a temporary registered manager in post who was managing the entire home until a permanent registered manager was employed. There was also a manager for each unit. Most people and relatives knew who the main registered manager was or knew who the unit manager was. People felt able to talk to the registered manager if they needed to. One relative said, "The manager is nice to speak to." Another relative said, "The manager is very approachable." A member of staff said, "I find the registered manager to be approachable."

However, there was some mixed feedback about the overall management of the home and communication. One relative told us, "One relative said, "Communication could be better between carers as one didn't know she could have a bath. A carer said they had not been told." Another relative said, "They keep changing

these managers but nothing else changes." One relative said, "Management sit in the office all day." A member of staff said, "We want a permanent manager, we need some stability and guidance." Another member of staff said, "We need consistency and stability from management." Another staff member said, "We need stability. We're having so many changes. We need a manager that is going to stay." Another staff comment included, "The staff on the units are not fully aware of who the registered manager is." Other relatives also fed back to us that they did not feel communication was always very effective from management. We saw that the provider had recognised in a recent audit that improvements were needed in engaging with people and relatives in meetings. When we asked the registered manager about this, they said, "I arranged another relative's meeting and there were posters up in each unit but no one came. There was also an open door after the meeting and only one relative came." The temporary registered manager also confirmed to us that plans were in place to ensure a permanent registered manager would be in place.

People and relatives were asked for their opinion about their care and support. One relative said, "I have done feedback and sent it back to them. No concerns at all." Other comments included, "Yes we have [been asked to feedback] and sent it back" and, "Yes they do ask and send us a form." We saw that results had been analysed and improvements were needed. The home had only just received the results from these surveys so had not yet had the opportunity to resolve any issues raised. The staff had not yet received a questionnaire, which the provider had identified in a recent audit.

Some relatives, staff and professionals told us they felt the service had improved since it was taken. A relative said, "The changes with the new owner have been gradual, but it is going well. I think it will be good." Another relative commented, "There has a been a vast improvement here." One staff member said, "It's got better since this provider took over." A health professional said, "I've been coming here for a number of years. It seems much more organised. The paper work is much better." Other professionals told us the service worked in partnership with them. One professional told us, "We now have a good relationship." Comments from other professionals included, "The provider had worked well with us and we were pleased with the improvements seen" and, "The management worked really well with us." We saw that some areas for improvement had already been identified and action was being taken, for example in relation to updating staff training, offering staff a questionnaire and changes to medicines audits were being implemented. This meant improvements to the service were ongoing and some improvements had been noticed by people. We saw that relevant notifications had been submitted as required by law.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always being stored and managed safely. We could not be assured people were receiving their medicines as prescribed and in line with guidance.