MMCG (2) Limited

Blenheim Care Centre

Inspection report

Ickenham Road
Ruislip
Middlesex
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 27 September 2017 and was unannounced. This was the first inspection of the service since it was registered with the provider, MMCG (2) Limited on 4 August 2017. Previous to this the service was registered with and managed by another organisation.

Blenheim Care Centre provides accommodation for a maximum of 64 people. The service has three floors and accommodates people in single rooms each with en suite facilities. to the ground floor was designed to accommodate up to 12 older people and 8 people with physical disabilities. The first floor was designed to accommodate up to 22 older people with dementia care needs and the second floor for up to 22 older people with dementia care needs. Each floor has communal dining, sitting rooms and bathing facilities. Nursing staff were employed to provide care on the ground and second floors. At the time of the inspection 51 people were living at the service.

MMCG (2) is part of the Maria Mallaband Care Group, a privately owned organisation providing care homes, day care and domiciliary care across the UK, Northern Ireland and Channel Islands.

The registered manager left the organisation in August 2017. There was a temporary manager in post. The provider was in the process of recruiting a permanent manager. 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 and associated Regulations about how the service is run.

The staff did not always care for people in a respectful way and sometimes focussed on the tasks they were providing rather than the needs and wishes of the people who they were supporting.

There was not enough information about how to meet some people's care needs within their care plans and this meant there was a risk they would receive care which was inappropriate or unsafe.

People's social and leisure needs were not always being met.

Care records were not always clearly maintained.

The provider had systems for monitoring the quality of the service and making improvements. However, these improvements were not always sufficient to address any identified shortfalls.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to person centred care, dignity and respect, good governance and staffing. You can see what action we told the provider to take at the back of the full version of the report.

The environment had not been suitably designed and equipped to meet the needs of people living with the

experience of dementia. We have made a recommendation in respect of this.

The staff took part in training in relation to their role but did not always demonstrate the skills and knowledge from this training. The staff were not always supported and supervised to make sure they met people's needs and understood their roles and responsibilities. However, the provider had started to address this and provide better training, support, supervision and information.

Some people felt there were not enough staff to meet people's needs and keep them safe. The provider had assessed staffing levels and felt that these were sufficient. We observed that the staff did not spend time engaging with people or supporting them for longer than physical care tasks. It was unclear whether this was due to staffing levels, the deployment of staff or custom and practice of the staff team. There were times of the day when there were not enough staff to support everyone at the same time, for example, during mealtimes. There were some instances where staff worked consecutive days without sufficient time off and this practice could put people at risk.

People were safely cared for at the service. Risks to their wellbeing were assessed and managed. People received their medicines in a safe way and as prescribed. The provider had procedures for safeguarding people from abuse and these were followed.

The provider acted within the principles of the Mental Capacity Act 2005 by assessing people's capacity to consent and making decisions in their best interests where they lacked capacity. They had made application for authorisations under the Deprivation of Liberty Safeguards where applicable. However, they had not always recorded that people had consented to their planned care when they did have capacity.

People's healthcare needs were being monitored and met. The staff worked closely with other healthcare professionals.

People were able to make choices about the food they ate and their nutritional needs were being met. Although some people did not feel they had enough choice of food. The kitchen staff did not always have the written information they needed about people's different nutritional needs, so there was a risk that they would not meet these needs.

The majority of people felt that the staff were kind and caring. They had good relationships with them and they were happy living at the service.

The provider had introduced a number of regular audits and checks in order to monitor the service. There was evidence they had taken action where they had identified areas of concern.

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

Some aspects of the service were not safe.

There were enough staff to keep people safe, but people sometimes had to wait for care and support. In addition, the planned use of staffing meant that sometimes staff worked for many consecutive days without sufficient time off.

People felt safe.

There were procedures designed to safeguard people and protect them from abuse.

The risks to people had been assessed and staff supported people in a way to minimise the likelihood of harm.

People received their medicines in a safe way and as prescribed.

People lived in a safe and clean environment.

The provider's procedures were designed to recruit only suitable staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The staff did not always have the support and supervision they needed to effectively care for people. The provider was aware of this and had started to address this issue.

The environment was not designed in a suitable way to support people living with dementia.

The provider was acting within the principles of the Mental Capacity Act 2005.

People's healthcare needs were being met and they had access to healthcare services as needed.

People's nutritional needs were being met.

Is the service caring?

Requires Improvement

The service was not always caring.

The majority of people felt that staff were kind, caring and they had good relationships with them. However, some people had experienced the staff being rude.

Some of the care provided did not show people respect or consider their individual needs and wishes. Although, some staff had a caring and sensitive way of supporting people.

People's privacy was respected and maintained.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care needs were not always planned for or recorded.

People were not always supported in a way which met their needs and reflected their preferences.

People knew how to make a complaint and felt that these were appropriately investigated and acted upon.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had plans for improvement and there was evidence that improvements had been made. However, these were not sufficient to ensure that people's needs were always met.

People using the service, their representatives and staff were positive about the way in which the service was managed and improvements which had taken place.

The provider had systems for auditing the quality of the service and there was evidence that they had improved some aspects of the service.

Blenheim Care Centre

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 comprehensive inspection took place on 27 September 2017.

The inspection team consisted of two inspectors, a nurse specialist advisor, a pharmacy inspector 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.

Before the inspection visit we looked at all the information we held about the service. This included notifications about significant events and safeguarding alerts. We also looked at the information we held about the service under the previous registration as some of this was still relevant.

During the inspection we spoke with nine people who lived at the service and eight visiting relatives and representatives. We observed how people were being cared for and supported. Our observations included a Short Observational Framework Inspection (SOFI) during the morning. SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We spoke with the staff on duty who included the manager, deputy manager, nurses, care assistants, catering staff and domestic staff.

We looked at the environment and examined records of environmental and equipment checks. We looked at how medicines were stored, administered and recorded. We looked at the care records of eight people who lived at the service in detail and additional sections of care records for 15 other people. We looked at the recruitment records for six members of staff. We also examined other records used by the provider for managing the service, which included staff training and supervision records, staff rotas, meeting minutes, menus, quality audits and records of complaints.

Following our visit we spoke with the quality monitoring officer from the local authority who visited the

home weekly and had issued an action plan where they had identified improvements were needed.

Requires Improvement

Is the service safe?

Our findings

Some people living at the service and some of the staff did not feel there were enough staff employed to keep people safe and meet their needs. One person told us that they often waited a long time for call bells to be answered. The staff told us that they did not feel staffing levels were sufficient, especially on the second floor where a high number of people required the assistance of one or two members of staff to move and at mealtimes. For example, they told us that 13 out of the 22 people living there required assistance at mealtimes. The staff told us it was ''extremely'' difficult to meet everyone's needs. We observed that during lunch time some people waited a long time for assistance and support, as they had to wait for a staff member to be free to assist them.

The staff also commented that there was a high number of agency (temporary) staff employed to cover sickness and vacancies and that this had an impact as they did not know the service well or how to meet people's needs.

The kitchen staff told us that there were not enough of them and that they had to work long shifts without sufficient breaks. For example, on the day of the inspection one member of kitchen staff had worked for 10 consecutive days and the other for 13 consecutive days.

We discussed staffing levels and the use of agency staff with the manager. They told us that the provider had assessed people's needs and felt that staffing levels met these. They told us they were in the process of recruiting permanent staff with the hope of reducing reliance on agency staff. The reason for the long working hours for the kitchen staff was that one of the team was on holiday and there had not been any replacement for this member of staff.

We looked at the staff rota for August and September 2017. We saw that the provider had maintained planned staffing levels using overtime and temporary staff. However, the staff felt that these levels were not always sufficient to meet people's needs.

We saw that the rota was generally well planned so that staff had adequate time off between shifts. However, there were instances when some members of staff worked consecutive long day shifts. For example, one member of staff worked six days in a row, including two 12 hour shifts, followed by one day off and then four more days in a row, including three 12 hour shifts. Another person worked five 12 hour shifts and one six hour shift over six days.
People who used the service and their relatives told us that they felt safe there. One person said, ''I feel completely safe with the staff and environment.'' Another person told us, ''There is nothing frightening here, we are all ok.''

The provider had procedures relating to safeguarding people from abuse. Information about these and what to do if someone suspected abuse was displayed around the building and available in staff offices. The staff had received training about safeguarding and whistle blowing. Some of the staff were not able to describe to us what they would do if they suspected abuse and could not tell us about different types of abuse. For

example, two members of staff told us that safeguarding people was protecting them from falling. We discussed this with the manager, who explained that they would ensure that the topics of safeguarding and reporting abuse were discussed with all the staff again in their individual supervision meetings. Other staff were able to give us detailed information about what they would do if they were concerned someone was being abused. For example, one member of staff said, ''I would report and record it, tell the senior who reports to the manager who [liaises with] the local authority safeguarding team.'' Another staff member told us, ''Whistle blowing is if you suspect your colleague is doing something wrong, you must report it to your supervisor, your manager, safeguarding team or CQC.''

The provider had taken appropriate action when concerns about safety and abuse had been identified. They had recorded information clearly and reported concerns to the local safeguarding authority. We saw evidence that they had worked with the local authority to investigate concerns and to protect people from the risk of further abuse.

We observed the staff supporting people to eat and move around the home. They did this in a way which kept people safe and checked on their wellbeing. We saw that a small number of people were seated in a slouching position when eating lunch. This meant there was a risk that they could choke on their food. We discussed this with staff at the time who encouraged people to sit in a more upright position. We noted that these people were able to move independently and had not been positioned by the staff.

The staff were able to tell us what they would do if someone fell or if they were injured. We saw records of accident and incident reports and these showed that swift action had been taken to keep the person safe and ensure they had the right medical support. There had been concerns raised about practice in this area in the past. However, reports from recent incidents indicated that this had been addressed and that people received the care and support they needed following a fall or accident. In addition, we saw that the manager analysed all incidents and accidents so that they could identify if staff did not follow correct procedures and if there were any links between these occurrences so that common issues could be addressed.

The staff monitored wounds and injuries and how people were being supported with these. There were clear records to show that people had received the treatment they needed and that staff tracked the progress of wounds to make sure they were healing.

The staff had created risk assessments for each person. These covered a range of different risks associated with their mental and physical health, moving safely around the service and skin care. In addition, there were specific assessments relating to people's known needs, such as a tendency to become agitated or a desire to leave the building without telling staff. The risk assessments were clearly recorded and showed who was at risk and the plan to minimise these risks. They were reviewed and updated monthly. We saw that the assessments were closely linked to care plans which included guidance for staff about how to care for each person.

People received their medicines safely and as prescribed. With the exception of one prescribed emollient cream which we found in a communal bathroom, all medicines, including controlled drugs, were stored securely and safely, in line with the provider's procedures. The storage areas were clean and well organised. The staff undertook temperature checks to make sure medicines were always stored in temperatures within the recommended ranges.

There were procedures for the administration of medicines, including homely remedies and PRN (as required) medicines. The staff were aware of these procedures and had received appropriate training. The manager assessed staff competency at administering medicines. The provider had procedures for the bulk

prescriptions of certain topical and liquid medicines. The procedures met required standards in relation to this and the staff made sure these medicines were handled safely and appropriately.

We witnessed the staff administering medicines and saw that they did this in a calm and professional way. They explained what they were doing to the person and asked about their pain and need for any pain relief. There were protocols for the administration of pain relief for people who did not have capacity, so that the staff could identify when the person was in pain and whether medicines were needed.

Medicines administration records were completed accurately and clearly. These were regularly checked and audited by senior staff. People's allergies were clearly recorded. The provider undertook audits on all medicines including stock checks. These showed that where issues had been identified these had been rectified and appropriate action taken. There had been two instances in the month before the inspection when the stock of a medicine had run out. We looked at how this had been managed and found that the staff had taken steps to ensure that the supply of medicines was available as soon as they could. There had not been any detrimental effect as a result of this and the staff had consulted with the GP to ensure the person would not have any adverse effects.

The GP visited the home regularly and reviewed people's medicines on a regular basis. We saw evidence that they consulted with the staff when reviewing medicines and that they had adjusted doses and changed medicines as needed.

People lived in a safe and clean environment. During the inspection visit we noted a number of repairs which needed to be attended to. The staff had recorded these and alerted the maintenance workers. The manager told us there had been a delay in repairs as there had been a vacancy in the maintenance team, but that this had been recruited to and the service now had two allocated maintenance workers who attended to repairs and had a schedule to ensure the health and safety of the environment and equipment were checked.

The environment was clean throughout on the day of the inspection. Domestic staff were seen using colour coded cleaning equipment. There were schedules for cleaning and infection control audits. Bathrooms and toilets were adequately equipped and there were hand sanitising dispensers on each floor. The staff wore personal protective equipment (such as gloves and aprons) for personal care and at mealtimes.

The provider had an appropriate fire safety procedure. They had updated the fire risk assessment for the building and everyone living at the home had a personal emergency evacuation plan. Summaries of these, outlining the level of support needed to help a person evacuate, were kept on each floor so the staff had easy access to information in event of an emergency. The provider had a contingency plan for dealing with different emergency situations and this was accessible for staff.

The provider had procedures to make sure only suitable staff were employed. They carried out formal interviews which were recorded and undertook checks on staff suitability. The checks included asking the staff to complete application forms with full employment histories, requesting references from previous employers, checks on identity and eligibility to work in the UK and Disclosure and Barring Service checks, which included evidence of any criminal records.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had been inducted and trained. However, the staff had not always received regular supervision and support. Therefore the provider had not always checked that they had the knowledge and skills to care for people. The staff we spoke to said that they did not take part in regular individual supervision meetings. Two members of staff told us that they had never had an individual meeting or an appraisal. The staff also told us they had not attended regular staff team meetings, although they said that these happened every few months. The staff told us they did take part in handovers of information each day and this is how they found out about the way they needed to care for and support people. We spoke with the manager about this. They acknowledged this was an area for development. We saw details of their intentions to meet with all staff on a regular basis and that this was part of their action plan.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a good range of written information available for the staff about their roles and responsibilities.

The provider had arranged for all the staff to take part in their on line training. The staff had started to do this and the manager was able to view how much progress they had made. The manager told us they were arranging for specialist training about caring for people living with dementia and this was due to take place in November 2017.

Newly employed staff were able to describe an induction process which included shadowing existing staff and completing training in line with the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

Some of the staff spoke English as a second language. Feedback from people who lived at the service and their visitors was that these staff did not always understand them or speak clearly to them. When speaking with some of the staff we found they did not fully understand the questions we asked and this meant that there was a possibility they would not understand all that was required of their role. The manager acknowledged that there were some language barriers but said that all staff were assessed to ensure that they could understand and communicate in English. The manager told us they would be reviewing staff knowledge of English through individual meetings.

The building had had not been designed to meet the needs of people who had dementia. The staff had decorated some areas with features, such as a painted mural, but there were signs of wear and tear in these areas and they were limited. There were no interactive features or things for people to touch or handle. In addition, the environment did not support orientation. For example, the dining room on two floors were labelled, ''Lounge.'' There was nothing to distinguish bathrooms, toilets and different parts of the building. The menus were not displayed clearly and some notice boards designed for displaying photographs of staff on duty were blank.

We recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

Parts of the building and furniture were in a poor state of repair. For example, we found chairs with ripped covers, broken panels, marked walls and a broken radiator. The manager told us the provider had made a commitment to update the environment and furniture and this work was due to commence shortly after the inspection.

People had personalised their own bedrooms with furniture and their own belongings.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked that the provider was acting in accordance with the principles of the Act and found that they were.

The staff had assessed people's mental capacity with regards to each aspect of their planned care. The assessments were clearly recorded and there was evidence that people's representatives had been consulted when people lacked capacity so that decisions could be made in their best interest. However, the provider had not always recorded the consent (verbal or signed) from people who did have capacity, and they should do to evidence that they have had these discussions and people have agreed to their care.

The provider had made applications for DoLS when people lacked capacity and had a register of these to make sure they made new applications when needed.

The staff said they had received training in MCA but they were not able to explain fully about the principles of the Act. We discussed this with the manager who agreed that they would look at ways to support the staff to better understand the training they had undertaken.

People were supported with their healthcare needs and had access to other healthcare professionals as required. Everyone living at the service was registered with the same GP surgery. The doctors visited the home regularly and there was evidence of good communication between the doctors and staff.

The provider employed 24 hour a day nursing staff. There was evidence that they took appropriate action to prevent, treat and monitor wounds. We saw that the staff made timely referrals for additional healthcare support, for example with the tissue viability nurses, speech and language therapists, physiotherapists and dietitians. These referrals were well documented and there was evidence that advice and guidance from healthcare professionals was included within care plans.

The provider had signed up to a local scheme designed to keep information about people's health and specific needs in one place so that these could be shared with health professionals and emergency staff if needed.

People were supported with their nutritional needs. However, some people told us they did not always like the food and did not always have a choice about the food they were offered. For example, one person told us that the staff did not check what type of bread they liked for toast and just assumed they wanted brown bread, which they said they did not like. Another person told us that sometimes sandwiches were made from frozen bread which had not been fully defrosted. One person told us that they never knew what they would be having for lunch until it was served. We saw that this was the case for others, with the staff bringing

people meals without first telling them about the choices. We saw that menus were not clearly displayed for some people so they did not have an opportunity to know what they would be eating. The staff told us that people were asked about menu choices the day before. We discussed this with the manager who agreed that some people may not remember the choices they had made and that this decision was not always meaningful for people as they had made the choice 24 hours previously. Other comments from people indicated that they felt the food was good. For example, one person said, ''There is a menu, it is okay, we can choose different things.'' A second person commented, ''The meals are very good and we have a choice.'' A relative told us, ''[My relative] has a pureed diet and the food always looks good and they like it.''

The staff had assessed where people were at nutritional risk and updated these assessments each month. There were care plans regarding people's individual needs and dietary preferences. However, this information had not always been clearly recorded in the kitchen. The kitchen staff told us that they knew about people's needs but they did not have records of these. Therefore there was a risk that the right food may not be prepared or available.

The staff regularly weighed people and recorded this. Weight loss and areas of potential concern were acted on and we saw that the staff had consulted dietitians and requested reviews from people's GPs to check if nutritional supplements might be indicated for the person.

We saw that people were offered drinks throughout the day and that cold drinks were available in communal areas and bedrooms. Bowls of fresh fruit were available in lounges but we noted that the staff did not offer these and people did not help themselves.

Requires Improvement

Is the service caring?

Our findings

Some people who used the service and their visitors told us that not all the staff were kind, caring or polite. Some of their comments included, ''I am not happy here, the staff are rude'', ''I am a bit concerned and I think things are going downhill. I don't like it here'', ''I am not happy because they treat me like I have dementia and they don't listen to me'' and ''The staff speak to each other in their own language and not in English.''

However, the majority of people and their relatives told us they had good relationships with the staff. They said that the staff were caring and friendly. Some of their comments included, ''[Member of staff] is lovely, they all look after you here'', ''It is lovely at this place'', ''The staff are all very kind to [my relative]'', ''The carers are good and look after [my relative]'', ''I am very happy, [my relative] has been here a long time'', ''The staff have the residents best interests at heart'', ''The care is ok, they do speak to me and tell me what they are doing'', ''It is better than my previous home'', ''The staff are kind and compassionate'', ''The staff genuinely care'', ''The carers do a great job'', ''They treat me well'', ''You couldn't get better'' and ''[My relative] is happy and pleased with the care [they] get.''

During our inspection we witnessed some interactions which did not show consideration and care towards people. For example, we saw a member of staff walk past a person twice, ignoring the person who was calling out to them.'' In another instance, we saw a person's shoe had fallen off. A member of staff approached them, placed their shoe back on their foot and walked away without speaking with the person. The staff placed paper aprons (clothes protectors) on people at mealtimes without consulting them or offering them the choice. In some cases people sat with aprons on for over 45 minutes before they received their lunch. The staff supporting people with their meals did not always speak with them to explain what they were doing or what food the person was being offered. They did not tell people when they had finished and sometimes left people in the middle of meals to attend to another task.

We observed that senior members of staff needed to remind other staff to offer people choices and to speak with them when providing support.

While the staff were polite, they did not always provide care in a person centred way and tended to focus on the tasks they were undertaking rather than the person they were supporting. For example, they brought people drinks and meals without interacting with them and sometimes forgot to bring cutlery or other essential items so the person was left waiting for these. We saw one person waiting to play a board game with the staff for over 20 minutes. When a staff member sat with them they did engage in the game, but left the person and the game as soon as it had been completed without checking on the person's wellbeing or asking them what they wanted to do next. As a result the person was left with nothing to do.

The above evidence was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some examples of positive interactions between the staff and people. For example, one person's

face needed to be cleaned after they had eaten. The way in which a staff member approached them and offered them assistance showed that they had thought about how the person felt and made sure they treated them respectfully and sensitively.

The staff respected people's privacy. We noted that they knocked on bedroom doors and provided care behind closed doors. The staff used a sign on doors which requested that people ''come back later'' as personal care was being provided. The staff had received training regarding privacy and dignity and individual care plans recorded how the staff should respect people when providing care.

Requires Improvement

Is the service responsive?

Our findings

People's care needs and how to meet these were not always clearly recorded. For example, we looked at a sample of care plans for people who had complex and multiple needs. We found that one person had a health condition which caused seizures. The guidance for the staff in event of a seizure was to lay the person on their side and to record the seizure. There was no information about the type of seizure the person experienced, other ways to keep them safe during a seizure and at what stage medical intervention would be required. Therefore the staff did not have the information they needed to care for this person and keep them safe. We found another person was being prescribed medicines for the same health condition. However, there was no information about this in the person's care records or the support they required in this area.

In another example, a person was being cared for at the end of their life and had been prescribed anticipatory medicines (to be administered to relieve pain and provide comfort at the very end of their life). There was no clear care plan relating to end of life care and for administering these medicines when needed.

People did not always receive care in a way which met their needs and reflected their preferences. For example, people's social and leisure needs were not always being met. The provider employed activity coordinators but there were limited organised activities at the service. On the day of our inspection, the majority of people did not participate in any activity, either as part of a group of individually. Records of care provided indicated this was usually the case for most people. A large number of people spent the day in their rooms. Whilst some people watched the television or listened to the radio in their rooms, others did not engage in any activity. People in communal rooms were not supported to take part in activities with the exception of a small number of short games. For the majority of the time the television was left on and people were not offered a choice about what to watch and did not appear interested in this. The staff interactions with people were short and they did not spend time engaging with people, asking them what they wanted to do or offer them choices. There was not many resources available for people to help themselves and they were not offered things to do, such as games, colouring, craft activities, knitting or things to read.

In one instance we saw that the staff had turned the television on but that they had left it on a channel which showed a schedule of upcoming programmes whilst that station was not on air at the time. The people using the service were left watching this and were not able to reach remote controls to change the channel. One person called out to the staff, but they did not take notice and the television was left like this. In another area of the home, the television was left on one station, where a programme started to air which had some content that people may have found offensive. The staff did not notice and the channel was only changed when a relative asked for this to happen.

We noted that in one person's life history written by their family they had expressed the importance of the person being given a daily newspaper. The care plan for this person did not include this information and stated the person liked, ''bingo, singalongs and listening to music.'' These activities had not been identified by the person's family as something they liked. The records of care provided indicated that the person did

not regularly receive a newspaper or take part in any other planned activity. Another person told us that they would like to read a newspaper but that this had never been offered to them.

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

The staff had created care records for each person. The quality of information in these varied. The care plans had been reviewed monthly, although changes recorded in monthly updates had not led to changes in the actual care plan and therefore it was not always clear how people's current needs should be met. In addition, some of the information needed to be archived and had not been filed according to the index. This meant that it was hard for the staff to follow the most recent and up to date care plans. The provider had started to audit all care files and we saw evidence of this where they had identified when improvements were needed. At the time of the inspection, the provider had only recently taken over the management of the service. The manager told us the long term plan would be to transfer all care records to the provider's own systems and that this would help improve how information was presented.

There were some good features of the care planning, including detailed life histories which had been written with or by families. These provided information about the personality and interests of the person and gave details about their life which were important and could be used to help staff understand and talk with the person about.

It was difficult to judge whether people's personal care needs were being met. Care plans included information about their basic needs, although they did not always include specific information about their preferences for how care should be delivered. The staff did not always record when they had offered people baths or showers or about the care they had provided. Therefore, the provider could not monitor whether the staff were meeting people's needs. We saw that people appeared well groomed and cared for, with clean hair, nails and clothes.

The staff told us they did not always get the opportunity to read care plans, but that they had good systems for verbally handing over information about people's needs. We found that the staff who we spoke with did have a good understanding about individual people and how to care for them. They were able to describe their personal and healthcare needs and individual characteristics and personality. The staff were able to explain about some of the challenges people who lived with dementia might face and about providing person centred care. However, our observations were that they did not always put this knowledge into practice. We observed that the staff tended to spend time supporting people with physical care tasks rather than checking on their wellbeing and offering emotional support. When the staff were not offering personal care or providing meals, we observed that they spent time completing paperwork.

The provider's complaints procedure was on display in different areas of the service. People who we spoke with told us they knew how to make a complaint. One person said, ''Yes I can speak with the manager about any problems and they address these.'' A relative told us, ''They listen to [my relative's] concerns.''

The provider had a record of complaints and how these had been investigated and responded to. There was evidence that appropriate action had been taken and that the staff had learnt from complaints.

Requires Improvement

Is the service well-led?

Our findings

People using the service and their relatives told us that they were happy with the new provider and manager. They felt that the service was improving and they were able to speak with the manager when they needed. They told us the manager was visible.

The local authority quality monitoring team commented that the provider appeared to have a ''good understanding of the needs of the home and improvements had been made.''

Some staff told us they had seen a lot of change with different managers and they did not know what changes the new provider would bring. Their comments included, ''It is too soon to tell'' and ''We do not know yet what will happen.'' However, the majority of staff spoke positively about the new provider and working at the service. Some of their comments included, ''I am so happy, this is a good company and they give us anything we need like new equipment if we ask for it, I am happy for now and the residents and relatives seem happy too'', ''The manager is very helpful'', ''The changes are good, the deputy manager and manager are helpful and encouraging'', "This company has a good vision for the future'', ''I love working here'', ''I really enjoy working with the residents'' and ''All the staff understand teamwork here, we have seen some good improvements, I love my job and every day is different and exciting.''

The staff told us they felt supported by the new manager, telling us they were approachable. Some of their comments included, "She comes up every morning to ask if there's any problems and have a look around", "For the first time ever I can have a conversation with my manager", ''The manager is always on the floor visiting on a daily basis and that she was very approachable'', ''The manager is very supportive and has a healthy attitude'' and ''She seems very nice.''

All nursing and care staff told us they felt supported and worked well as a team. They told us they felt supported by each other and that there was good communication at the service. Some of the staff in other departments appeared less happy and felt improvements were needed.

There was evidence that the provider had started to address previous areas of concern and there was a clear action plan for improvements. In addition, the local authority was working closely with the service. They told us that they felt there were steady improvements and they were happy with the provider's planned work for further improvements.

However, we found that some areas of the service required improvements and not all the required Regulations were being met. In particular we found that people did not always receive person centred or respectful care. People's needs were not always recorded and it was hard to judge whether their needs were always being met. Improvements were needed in the environment and in ensuring that the staff were appropriately supervised and supported.

Some records were not clear or appropriately maintained. We also found some errors in assessments undertaken by the staff, for example where assessments were based on a scoring system the staff had not

always added these up correctly, therefore recording an incorrect score and risk for the person. Daily care notes did not always clearly record the care people had received.

Whilst the provider had systems for monitoring the quality of the service and risk these had not always been effective in ensuring people's needs were met.

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

The registered manager left shortly before the inspection. The manager working at the service had not applied to be registered and told us the provider had not made definite arrangements for the future management of the home. It is a condition of their registration that the provider has a registered manager in post at the service and we advised the manager that an application in respect of this would need to be made.

The provider had introduced a number of daily, weekly and monthly audits. These included checks by the staff, manager and senior managers. The audits identified shortfalls and the manager had created action plans to address these. We saw evidence of care plan audits, checks on wounds, accidents, incidents, changes in people's weight, hospital admissions and infections. There was evidence that the provider had taken action where they had identified concerns.

The provider had an action plan for improvements which included looking at how staff were supported, trained and supervised. They had arranged for specialist training around the experiences of people who were living with dementia for all the staff, and this was due to take place in November 2017. The provider was also undertaking work to improve menus at the service and support the staff to have a better understanding of the importance of nutrition. The provider was planning to introduce new systems for recording care plans and care provided.

Improvements they had already implemented included work on personal emergency evacuation plans, improving fire safety and working with other healthcare professionals to share information about people's healthcare needs.

There were good systems for communicating with the senior staff team, so that they were all aware of plans for improvement.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not always ensure that service users were treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always operate effective systems and processes to assess, monitor and improve the quality of the services provided. Regulation 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure

Treatment of disease, disorder or injury

that persons employed received appropriate supervision and appraisal to enable them to carry out the duties they were performed to do.

Regulation 18(2)(a)