# Cavendish Healthcare (UK) Ltd

# Canterbury House

**Inspection report**

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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? | Good |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Inadequate |

## Overall summary

This unannounced inspection took place on 20 and 21 July 2015. Canterbury House is purpose built to accommodate up to 63 older people and people living with dementia. At the time of our visit 41 people were residing at the home. We had previously inspected this service on 13 August 2013 where it met the minimum requirements laid out in previous legislation.

The manager was present throughout the inspection and is registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The manager of the service was well liked and knew people and staff at the service well. People found him easy to talk to. People felt safe at this service and were supported by adequate numbers of staff. Staff had a good baseline of training, but the induction and supervision of staff could be improved as people's experiences of new staff was not always positive.

People received their prescribed medicines and had access to healthcare services. The feedback about

# Summary of findings

catering was mixed with people being complimentary about the lunchtime meal, but less so about quality and choice of supper. Feedback about how people spent their day was not positive. People wanted more options with activities. People were capable of expressing their views but these were not readily captured and responded to effectively.

The home was well designed for people with physical disabilities and good quality decorations and furnishings. We found a breach of regulation because infection control could be improved in areas such as the laundry and sluice.

We identified a breach in regulation because people's needs were always met, because the care planning process was not always sufficiently person centred and potential health risks had not always been managed well. People were not involved with their care planning and matters such as diabetes were not comprehensively addressed.

We identified a breach in the handling of complaints because there was a lack of effective systems and necessary and proportionate action in relation to complaint handling. People did not feel as though they were truly listened to and responded to. Systems in place were not comprehensive.

The overall lack of good governance to assess, monitor and improve the home including seeking and acting upon people's feedback identified a breach in regulation. The provider lacked a comprehensive and systematic oversight of the home and was unaware of events and feedback from people using the service. Whilst there were some systems of monitoring and auditing these needed to be more rigorous and continuous.

You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## 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 always safe. The general environment was clean, but the practice in the laundry and sluice created potential sites of cross infection.

There were sufficient numbers of skilled staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse, and acted appropriately to protect people.

Most risks had been identified and managed appropriately. Assessments had not always been carried out in line with individual need to support and protect people. E.g. assessing risk of sore skin.

People received prescribed medicine, but storage temperatures were not addressed and one record relating to controlled drugs was incorrect.

**Is the service effective?**

Requires improvement

The service was not always effective. People did have appropriate access to healthcare but did not always receive care and support that met their needs. E.g. diabetes care.

Staff received ongoing training, but the induction of new staff was not as thorough as needed. Supervision of staff was not adequate.

Staff were due to receive training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of respecting self-determination and day to day decisions.

People were supported to maintain a healthy diet, but their feedback and choices were not always respected.

**Is the service caring?**

Good

The service was caring. People were looked after by staff that treated them with kindness and respect.

People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

**Is the service responsive?**

Requires improvement

The service was not always responsive. Care records were not personalised to meet people's individual needs.

People were not routinely involved in planning their care.

Activities were not planned in line with people's interests.

People's complaints and concerns were not taken as seriously as they wanted. People's experiences were not always taken into account to drive improvements to the service.

# Summary of findings

**Is the service well-led?**

The service was not well-led. The management team were approachable and friendly, but people at the service did not find them effective and responsive to their feedback.

Quality assurance systems were not comprehensive and did not drive improvements and raised standards of care.

**Inadequate**

# Canterbury House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 20 and 21 July 2015 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information before the inspection. This included all records that CQC hold about this service including, statutory notifications. These are events that the manager is legally obliged to notify us about. We had also been contacted by relatives and staff who worked at the service and therefore used their feedback to plan our visit.

The methods that were used included talking to eight people using the service, four relatives and friends or other visitors. We spoke with 14 staff, and pathway tracked five people who lived at the home. We observed care and support in all areas of the home and reviewed records. We examined eight care plans of people living at the home. Staff records included rosters, recruitment and training records. In addition we looked at audits and quality assurance records related to the running of the home. Following the inspection we spoke with two health and social care professionals.

Requires improvement

# Is the service safe?

## Our findings

The home had a light airy feel with quality décor and furniture, but there were some risks of cross infection. One person told us, "The laundry seems to mess things up. I've had clothes ruined because they've been ironed incorrectly. There's been successive people running it and it's only staffed in the morning. Some washing comes back still with marks on." We identified the following risks; hand towels were being used rather than paper towels in some areas of the home such as the laundry, medication storage room and the sluices. In two sluice rooms we noted that bins did not have covers, were overflowing with soiled items in one room and there was a strong odour of soiled items from one of the bins. We noted that a carpet cleaner was also stored in one of these rooms. In the laundry we found soiled clothes soaking. The person employed to work in the laundry had not received specific training for their role in handling soiled clothing to prevent the risk of cross infection. We read the home's infection control policy. The policy did not refer to which guidelines it was following or who was responsible and what monitoring should be in place to ensure that a clean and safe environment was maintained.

**This was a breach of the Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).**

People told us they felt safe living at Canterbury House. One person said, "I'm safe and comfortable here." One person said, "I feel very secure and safe here which is so important when your state of health requires others to care for you. This is a good place to be." Another said, "I've never heard staff shout at anyone. They are very good and know what they are doing." A relative said, "My mother is safe and secure here."

Four members of care staff told us they had received training to enable them to keep vulnerable people safe from abuse. They each informed us how they would report any concerns or allegations of abuse to the Local Authority should they need to. There was a policy and procedure in place that was reviewed in 2013. This set out guidance for staff and included correct contacts within the local authority. We followed up matters of safeguarding with the manager. They were able to show us outcomes of investigations and actions taken to prevent a similar occurrence.

People were supported to take everyday risks. We observed people walking freely around the home and going out into the community. One person said, "I leave the home when I want and write it in the book." Risk assessments recorded concerns and noted actions required to address risk and maintain people's independence. For example, one person had their food and fluid intake monitored for three days. Staff had been concerned about the findings and had referred to a medical practitioner and sought advice. This had been followed and we saw that the person had gained weight and maintained better heath. The same person had fallen and a falls risk assessment was in place. We saw they had not fallen in the last three months. Therefore both sets of intervention were working for this person.

Risk assessments highlighted people at risk of skin damage. Staff knew who required frequent moving to reduce the likelihood of a pressure ulcer developing. People at risk of skin damage had special mattresses and cushions to maintain their skin integrity. In one case we saw that their risk assessment called a 'waterlow' had been incorrectly calculated. This had not taken account of their diabetic condition which would have boosted their score by four to six points. This may have placed them at higher risk. We fed this back to the manager and they agreed to take action with these records immediately.

People at the service expressed concern about staffing levels, but staff said there were enough staff on duty. One person said, "When I call for help it can take a bit of time, sometimes a long time. I just think at certain times they are short staffed." Someone else said, "It's true that in busy periods, it can take up to 20 minutes for someone to arrive after pressing the buzzer." A relative said upon return to the home with their relative, "We walked around the building for 20 minutes until I found someone to tell them mum was back."

We looked into these matters. The building is spacious and large so staff do cover a wide area. We examined the call bell system over a 24 hour period on a recent weekend. We found that the vast majority of calls were answered within three minutes. At key times such as breakfast and lunch this increased for a few calls to five minutes. One person in that 24 hour time frame waited seven minutes. At the inspection we spoke to the manager about the feedback and people's perceptions of waiting times and suggested how he may wish to monitor this and feedback to people. The manager told us how he determines numbers of staff

Requires improvement

# Is the service safe?

on duty. The manager showed us the staffing formula they used to determine the numbers of staff employed. The home had a plan to provide a level of staffing related to the numbers of people living at the home, rather than an assessment of people's needs and dependency. There was not a clear approach in place to ensure that people's dependency needs were accounted for when the staffing levels were being planned. However, the manager was aware of the needs of matching staff to the differing needs of people and described how a mixture of experienced staff and new staff were being used. We also found that consistent members of staff were working in the home to provide suitable support for people with dementia related care needs. We also saw evidence in the staff roster that overall, a consistent level of care staff had been deployed to support people.

Six care staff we spoke with told us that they considered there were sufficient numbers of care staff working at any time to allow them to respond and provide suitable support to people. One member of staff told us that if additional staff were considered necessary to provide appropriate support for people, they had advised the manager who had then arranged for more staff to be provided. Two further members of staff told us that when staff had been required in an emergency additional care staff had been provided either through an existing arrangement with an agency or by using their own care staff to ensure there was always adequate numbers of care staff working. We concluded there was adequate staff on duty and could find no detrimental impact upon people.

Safe recruitment practices were in place and records for four members of staff whose records we looked at showed appropriate checks had been undertaken. All of these four staff had been screened for a satisfactory Disclosure and Barring Service check, prior to commencing employment. Staff confirmed these checks had been applied for and obtained before starting their employment with the service.

People received their medicine when they need it. One person said, "My medication is given on time by a Senior." Another person said, "I'm in charge of my own medication because of my independence."

Medicines were managed, given to people as prescribed and disposed of safely. The Medication Administration (MAR) charts had been appropriately and carefully recorded to ensure that there was a correct record of the medicines that people had been given. We observed that people were given their medication in a safe and timely manner and that people were clearly informed of their medication and were asked whether they wanted their 'as and when needed', or PRN (pro re nata) medicines. We spoke with one person who said they were fully aware of the medicines they were taking and what they were for and that they had a choice about whether to take them or not. They also said, "I was asked if I wanted to manage by own medication, but I did not want to".

We found that one Controlled Drug (CD) had been incorrectly recorded in the CD record book. As a consequence the amount of this medicine did not tally with the records they had made. We brought this to the attention of the manager during the inspection who agreed to look into the record.

Medicine was secure and appropriately stored except for the storage temperature. The room where medicines were stored had recorded temperatures of between 22- 29C, at 8am each day for the previous week. The room was very warm during the time of the inspection and a portable air conditioning appliance was mounted on a desk top area to cool the room. The room did not have an automatic cooling system or method of controlling the temperature to a suitable level of below 25-C. Medicines constantly stored above the manufactures recommended temperature will over time alter the chemical compound and risk making them ineffective.

Canterbury House had a written Medicines Policy, but temperature storage had not been included in the policy and there was no reference to which published professional guidance the home was following.

Requires improvement

# Is the service effective?

## Our findings

Two people at the home felt the staff group were young and lacked life experience. One person told us, "I don't know how new staff are introduced into the system. [A member of care staff] started yesterday but didn't know how the shower worked and here they were looking after people. They didn't know about collecting towels. It seems to me it's a case of, 'Get on with it.' Surely they should be put with an experienced person for a time."

We looked at the induction arrangements for three recently employed care staff. The induction arrangement for new staff was weak and could be improved to ensure that new staff receive adequate and comprehensive training prior to working alone, or unaccompanied by another care assistant. We saw that the induction programme was brief and consisted of a single day induction in a number of listed topics and then a period of working alongside a colleague. This did not correspond to what people living in the home told us. No formal training had been identified for staff induction and there was no monitoring arrangement recorded and no supervisory notes about a member of staff's progress through their induction period. For staff new to working in a care service this was not adequate and could represent a risk of unsafe care being given to people. We brought this matter to the attention of the manager during feedback.

Staff received a range of training as stated in the training matrix. This included training to keep people safe such as, moving and handling, fire safety, first aid, health and safety and food hygiene. Some staff had additional training in administration of medicines and supporting people living with dementia.

Supervision had not been provided to all staff and the new staff were not supported during induction with assessment and formal feedback of their performance. Staff were not properly supported through supervision and it had not been systematically planned and delivered to all staff. This was set to improve with the recent employment of a deputy manager who was already providing support to staff on a daily basis.

People when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who may have their liberty restricted to keep them safe and provides protection for people ensuring their safety and human rights are protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves. DoLS applications had been appropriately made. The service was aware of the legal process they were required to follow and sought advice appropriately from the local supervisory body. People's capacity was regularly assessed by staff. Staff showed a good understanding of the main principles of the MCA and followed this in practice. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. Staff members told us they gave people time and encouraged people to make simple day to day decisions. We saw examples such as plated up meal choices for people living with dementia and at what time people wished to go to bed and get up in a morning. Staff spoken with said they had not received training in DoLS but that this was due shortly.

People were complimentary about the lunchtime main meal of the day, but consistently less so about the evening supper. One person said "The food is very good and there's enough. There's no chef around at supper time and there's less choice and I have to say the quality is not good. We would like to have something cooked." A different person said, "We used to have a cooked tea but no longer. Some food is heated up in a microwave but it's not good and the sandwiches aren't great either." Another person said, "Food's not bad - breakfast is the best. Supper is not much to write home about."

We spoke to the chef who was aware of special diets and had a list to refer to for people who had different textured, fortified and finger food. This list also indicated who was diabetic. The chef said they followed the list but was due to increase their knowledge about food for people with diabetes on an upcoming course. The supper planned for that day was soup, salad, sandwiches and frittatas.

We observed the lunchtime experience in two different parts so the home. In the main part people were supported appropriately with ensuring they received the ordered choice of food and were offered different drinks including wine. In the part of the home where people are living with

Requires improvement

# Is the service effective?

dementia, people were given additional support. People were shown plates of food to decide what they would prefer to eat. Staff supported people to eat and conversed and encouraged people at a pace that suited them.

People's care records highlighted where risks with eating and drinking had been identified for example where there had been weight loss. Staff monitored these people's diets. Where necessary GP advice had been sought and supplements prescribed or fortified diets provided from the kitchen. We fed back to the manager our findings on people's experiences of eating and drinking and their desire to influence changes. They agreed to address this matter.

People had their health needs met. One person told us, "When I was sick, they sent for the doctor straight away." Another person said, "There's a practice nurse comes round but if I want a doctor, I ring my own and they will take me."

Feedback from health professionals was that staff communicated well with them and made appropriate referrals for their services. Records showed that people had access to a range of community healthcare professionals to support their health needs and received ongoing healthcare support, for example, from opticians, dentists and chiropodists. Staff promptly sought advice when people were not well, for example if they had a suspected urine infection or chest infection.

Good

# Is the service caring?

## Our findings

There was mixed feedback in terms of people being involved in their care and influencing the running of the home. On a day to day basis people were given choice and this was respected. People were able to determine how to spend their day and make decisions and these were respected. One person told us how they had fed back about the food and suggested pineapple fritters and sardines go on the menu. One person said, "I don't need people asking me if I'm happy with things because I'll tell them first if I'm not happy and it will get done." Two different relatives said they had not been consulted on the care of their relative. One went on to say, "If I want something done. I have to tell them." Records in terms of care plans had varying evidence. We saw that where people had capacity, people had not always been involved in reviews but in other cases they had influenced their care plans and had been consulted in decision making.

In terms of relative and users meetings. The manager told us one had been held last November 2014 and another was planned. Therefore there was limited scope for people to influence the running of the home and be involved in what mattered to people.

The atmosphere in the home was calm and the staff were organised and friendly. Caring positive relationships had been developed between staff and people who lived at the service. A majority of people had positive comments. One person said, "The carers here are a lovely lot and we joke and laugh together. I am more than just a person to them. They cheer me up when I feel a bit down." Another person said, "staff know me well. They know when it's my birthday and they treat me like royalty on that day. It feels like a family here." There were a few people who expressed reservations about the younger staff employed at the home. One person said, "The young carers seem to struggle to get up to speed. " One person said, "75% of the carers see you as a person in your own right but some see you as their job." This aspect was fed back to the manager on the day. They were aware of this and had taken steps to address these matters in their latest recruitment drive.

We saw that people were treated with dignity and kindness when they were spoken to by staff. We saw that staff ensured they knocked, waited for a reply and called out at doors before entering people's private rooms. One person said, "They knock and wait before entering the room."

We spoke with staff and it was evident that they knew people very well. Staff were able to speak confidently about how people liked to be supported and what their individual preferences were. Staff were respectful in how they addressed people and were mindful of confidentiality. One person told us, "Staff are friendly. They don't talk about residents in front of me." Another person said, "I'm on first name terms. We have nicknames for each other which makes things fun. They're all nice to me. They are respectful to me. It all makes me feel happy and content. When I see other places on TV and in the news, it makes me feel I'm in a gold mine here."

We found that staff were very responsive to people and familiar with and understood the behaviour needs of several people who were living with dementia. We observed that people were easily included in conversation with care staff and that a calm atmosphere prevailed. An example of this was a person showing distress as they claimed the room they were in was not theirs anymore. The two carers nearby handled the situation sympathetically and pointed out the things in the room that they recognised as their own and their agitation ceased and they settled back in their room reassured and happy that they had made a mistake.

Requires improvement

# Is the service responsive?

## Our findings

We had concerns raised with us about people not receiving personalised care that was responsive to their needs. Most people had their needs assessed before they came to the home. Therefore the staff could be prepared and meet those known needs of people. However, with no prior knowledge of their health and care needs known by staff at the service, we found that a person had been admitted at a weekend. This person did not have their needs met and their health and wellbeing was put at serious risk. We wanted to know if people contributed to their care plans and had been consulted. One person said, "I've never seen my Care Plan, but I'm not bothered. I know they update it but I must admit I've not seen them do it. They don't ask me about it." Another said, "What Care Plan?" A different person said, "I've seen a care plan, but frankly there's too much legislation to do these things. I see them filling in forms so I can imagine that's the care plan."

A complaint we received raised concerns that the home had not managed their relatives health in relation to diabetes and staff had not noticed their condition deteriorate. We wanted to know if lessons learnt had been integrated into practice. Staff were able to tell us who had a condition of diabetes. We looked at all these peoples care plans and found that no one had a comprehensive care plan that would address all their health and care needs associated with managing their diabetes. One person did not have any mention in their plans about being diabetic except in their preadmission assessment. This person was paying privately for a chiropodist when this would be free on the NHS because of their condition. One person who was diabetic was also on Warfarin and had an infected toe. These three things had not been linked. We fed back our findings to the manager who explained that diabetes training for staff had been booked. We were not confident that staff currently would know how to avert and manage changing blood sugar levels.

We consistently saw that care plans did not have a life history. This would enable staff to deliver personalised care and better support people living with dementia. We spoke to the senior on duty and they were knowledgeable about individuals people's needs, but in care plans where people exhibited distressed behaviour linked to their dementia we found these generic. Plans stated distract or diffuse a situation but did not say what specific action would help an individual. E.g. making a cup of tea, walk in the garden or looking a family photo. We found that the service was not consistently providing person centred care as set out in legislation.

**This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).**

People's preferences, aspirations and how they spent their day was not always respected. One person told us the swimming pool on site was marvellous and that they used it regularly. One person told us, "There's nothing much to do here. I used to do a gymnastic kind of thing with lots of exercises, but that stopped and I miss that like hell. There's not many visitors- no schools for example." One person said, "There's nothing going on really. Some of us make knitting squares."

Another person said, "There don't seem to be any activities really. I don't think residents want any. There's no list up anywhere, so I don't know what's on. There's not really visits out as there's no minibus." A relative said, "He spends a lot of time in his room watching TV."

On the day we observed care staff playing dominoes and scrabble with people. Others were walking the grounds. Some people did access the local community. People and relatives said they could have visitors whenever they wanted.

Two relatives told us that they were unhappy about matters and had complained, but did not feel that they had been listened to in a way that would improve the service for others or their relative. On person said, "They'll take notice of me if I make a big fuss." A different relative said "If dad is unhappy about something they take notice but don't act upon it".

There was a complaints procedure in place that people could access, but this did not tell people who external to the organisation they could escalate matters to, such as The Ombudsmen. We looked at records of complaints made. People did receive a response to their complaint, but not all were satisfied with the outcome. Complaints were not systematically logged. It was not clear that these had been used to develop learning within the staff group or any future preventative strategies developed. This was fed back to the manager who agreed that they needed to develop a better system for logging and monitoring complaints at the home.

Requires improvement

# Is the service responsive?

The lack of effective systems and necessary and proportionate action in relation to complaint handling meant:

**This was a breach of the Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).**

Inadequate

# Is the service well-led?

## Our findings

Whilst we saw some audits in place such as those of care planning and oral hygiene and the manager had started to develop strategies for monitoring falls prevention, we did not see a comprehensive reporting system that was effective and drove improvements. There was no leadership for infection control and any governance and monitoring systems in place to ensure that regular checks were conducted. Improvements to the monitoring of medication could be achieved, as errors were not being identified. We did not find any systematic monitoring of staff performance and their competencies. There was no clear system to monitor staff performance at induction level and afterwards, apart from the supervision that staff received. The records showed that this had not been undertaken in a systematic way or provided for all staff. We found that was not a clear approach in place to ensure that people's dependency needs are accounted for when the staffing levels were being planned.

Systems to learn from previous complaints and safeguarding matters were not driving improvements. The manager was not fully aware of their responsibilities under the 'duty of candour'. This was a change in the legislation that requires services to take responsibility when things go wrong, investigate, inform people about the event and apologies where needed. In information that we were sent and examined we found that the manager had not fully understood their responsibility. The manager agreed to make the changes required.

We saw that there was a system to plan for general maintenance to be carried out. However, staff reported that some repairs had not been acted on. Relatives and people informed us that they were not satisfied with the system to carry out some aspects of maintenance. One person said, "I think they should employ a handyman gardener around the place as there's so much to do. There's this firm comes in but there's no personal touch and repair jobs take ages to get done." A different person said, "It's over a year since the outside light stopped working and it's still not working. He's not a doer, he's a talker. It took 2 weeks to sort my shower head out." On the day of our visit we saw two areas of repairs that needed to be actioned promptly. One was the storage cupboard for care plans – the lock was insecure and records were accessible the other was the door to the lower part of the home for people living with dementia – this did not close properly when people used the door and people had unrestricted access to stairs. Both were brought to the attention of the manager on the day.

The overall lack of good governance to assess, monitor and improve the home including seeking and acting upon peoples feedback meant:

**This was a breach of the Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3).**

The manager took an active role within the running of the home and had good knowledge of the staff and the people who used the service. A new deputy manager had been appointed. They were developing lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. Staff comments were that they felt included and worked as a team.

People using the service did not experience a service that was inclusive and empowering. Two relatives said that they had not been asked their views on their parents care. One said, "If I want something done. I have to tell them." A person at the service said, "We had one residents' meeting a year ago. He said we'd have one once a month but he's never followed that promise." The level of negative comment about leadership of the Home was high, despite respect for the caring nature of the manager. One person said, "[The manager] tries to get things done. He's a nice man with his heart in the right place. Another person said, "[The manager] is 51% effective." One relative said, "[The manager] is a good listener and will say 'yes' to anything you suggest. Unfortunately that's usually where it stops."

The service was not clear about its overall aims and objectives for all aspects of the service. The main part of the home was aimed at 'hotel type living' for older people. One part of the home was supporting people living with dementia, but this part of the home was not clear about the model of care on offer. The staff training was not linked to a philosophy of working and the environment though modern and accessible for people with physical disabilities was not as dementia friendly as would be expected for people living with dementia to promote independence.

The registered manager informed us they were supported by senior management. The provider and senior managers

Inadequate

# Is the service well-led?

within the organisation did not have a comprehensive oversight and reporting structure in place to know what was happening within this home. There were sporadic visits that produced reports, but these visits and reports did not comprehensively monitor and test the service on offer.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>People's needs were always met, because the care planning process was not always sufficiently person centred and potential health risks had not always been managed well. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br>There was a lack of effective systems and necessary and proportionate action in relation to complaint handling. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>There was a lack of good governance to assess, monitor and improve the home including seeking and acting upon peoples feedback. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>Standards of hygiene were not adequately maintained in all areas of the home. This presented a risk of cross infection. |