Care UK Community Partnerships Ltd

Silversprings

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?	**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 13 February 2017 and was unannounced.

The service provides residential and nursing care for up to 64 people, some of whom are living with dementia. The service had recently changed its registration to include the provision of nursing care. At the time of our inspection 57 people were using the service including one person on a respite stay.

We carried out this inspection in response to concerns related to the management of medicines raised by Essex County Council Quality and Improvement team. We carried out a comprehensive inspection and looked at all areas of the service as well as looking in detail at the management of medicines. The previous inspection of this service had been carried out on 11 May and 9 June 2016 and the service had been rated Good overall but improvements had been required with regard to the safety of the service.

A registered manager was not in post but a manager had been recruited and was due to begin their employment in the next few weeks. A temporary manager had been employed at the service since October 2016. 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.

At this inspection we continued to have concerns regarding the safety of the service and the management of medicines in particular.

Medicines were not managed safely and recent improvements made in response to a safeguarding issue raised by Essex County Council had not been applied to other areas of the service. This placed people at risk of harm.

Staffing levels, and the deployment of staff, were significant concerns for many people who used the service, relatives and staff and we observed people failing to receive prompt care and treatment to meet their needs. There was a lack of strategy related to the deployment of staff.

Risks were assessed and documented in care plans but staff did not always manage risks effectively as set out in people's care plans.

Infection control measures were in place and staff had a good understanding of how to limit the risk and spread of infection.

Staff were trained in safeguarding people from abuse and the manager referred incidents appropriately to the local authority safeguarding team for investigation.

Staff received a good induction and training to help them carry out their roles. However, some relevant training was not provided to all staff. Staff were supported with regular meetings, supervision and appraisal.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals and relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. Some practice related to MCA and DoLS was very good but some staff demonstrated a lack of understanding with regard to DoLS.

People who used the service praised the food and people were referred to dieticians if they required this. Support at mealtimes for people who needed help or encouragement to eat and maintain their weight varied, but in most cases was good. Oversight of people's nutritional needs was good.

People were supported to access the healthcare support they needed promptly. There was evidence of good partnership working with the district nursing team and improved communication with the local GP service was seen as a priority by the manager.

Most staff were very caring and treated people respectfully, ensuring their dignity was maintained. Others were less caring and demonstrated a lack of respect.

People who used the service, and their relatives, were involved in planning and reviewing their care and had opportunities to feedback about the service.

People were supported to follow a range of hobbies and interests. However, people living with dementia and those unable to go out independently lacked stimulation. Staff understanding of the needs of people living with dementia varied.

A complaints procedure was in place and complaints were very well managed with information shared with staff and lessons learned.

The current manager had been brought in to stabilise the service after many management changes and to drive improvement. They had worked hard to bring about change and improvement but the staff team was not working cohesively and staff were stressed and not well motivated.

Audits were in place to monitor the safety and quality of the service but some were not effective in identifying concerns and effecting change. The manager had innovative ideas and was skilled and experienced but was not managing to successfully bring about the cultural change required within the staff team.

We found two breaches of regulation during this inspection. You can see what action we have told the provider to take at the back of this report.

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 safe.

Medicines were not managed safely and placed people at risk of harm.

There were not enough skilled and experienced staff and staff were not always deployed in a way which ensured people's needs were met promptly.

Risks were assessed but staff did not manage all risks appropriately.

Staff understood their responsibilities with regard to safeguarding people from abuse and had received appropriate training.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training in MCA and DoLS and some practice was very good but some staff demonstrated a lack of understanding.

Staff received a comprehensive induction and training although some relevant training had not been provided.

People were positive about the food and people at risk of not eating enough were well monitored.

People were promptly supported to access healthcare professionals when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback from people who used the service and relatives was positive about the kindness and patience of the majority of staff but we observed that not all staff were caring and patient.

People's privacy and dignity was not always maintained.

People, or their relatives, were mostly involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were assessed before they were admitted to the service and they, and their relatives, were mostly involved in assessing and planning their care. Care plans, although detailed, were not always followed by staff and people's individual needs were not always met.

People were supported to follow their own interests and hobbies but specialist provision for people living with dementia could be improved.

A complaints procedure was in place and formal and informal issues were very well managed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Following many changes in the management of the service the staff culture was poor on certain units and some staff were demotivated and did not feel supported.

Recording systems were not easy for staff to use which had an impact on the accuracy and timeliness of record keeping.

Audits designed to assess and monitor the quality and safety of the service were in place but did not always effect change. The manager had oversight of the issues at the service but did not demonstrate an ability to support and motivate all the staff.

Silversprings

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 13 February 2017. The inspection was unannounced.

The inspection team consisted of three inspectors, a nurse specialist adviser 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. Our expert had experience of services for older people and of dementia care.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with seven people who used the service, nine relatives, one visiting healthcare professional, one member of the domestic staff, four care staff, four senior care staff, an agency staff member, three nurses including the clinical lead, an activities co-ordinator, the administrator, the manager and the regional director. We observed staff providing care and support and we used the Short Observational framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not communicate with us easily.

We reviewed six care plans, 39 medication records, five staff files, staffing rotas for the weeks leading up to the inspection and records relating to the quality and safety of the service and its equipment.

We received feedback from Essex County Council Quality Improvement team both before and after the inspection visit

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service and were positive about the security of the service. One person said, "There is security on the front door and alarms on my patio doors which open onto the garden". People trusted the staff to keep them safe, although everyone spoken with felt that insufficient staffing made people feel insecure at times. One person explained this saying, "I can wait for up to half an hour for a bell to be answered. It hasn't affected me but how do they know I haven't fallen on the floor? That's a worry".

Two nurses, two senior staff, four care staff, four people who used the service and four relatives all made negative comments about staffing to us and explained how this affected them. Three people who used the service commented that they often get up later than they would choose to. One person explained, "I didn't get up until 10.30. That wasn't my choice. I prefer to be up by 8". Another said, "I'd like to be up earlier than they get me up". A third person commented on the number of staff supporting people doing activities. They said, "On some days there are 20 plus residents in the lounge for activities with [staff name] on her own. We don't mind helping but we shouldn't have to".

We observed times when no staff were present in communal areas as well as observing one person having to wait 15 minutes for someone to take her to the toilet as she wanted a female member of staff and only a male member of staff was available. We noted that a district nurse came to change a person's dressing but no member of staff was free to show them where to go as they were all busy.

Organised activities took place in the communal area of the ground floor rather than on the individual units. Staff were unsure about how many staff should accompany people downstairs when they went to take part in activities. This meant that sometimes the units were short of staff, especially if the senior staff member was administering medication.

Although units were reasonably well staffed on the day of our inspection we saw that the service had 200 vacant staffing hours to fill each week, including 60 nursing hours. Staff told us that sickness and annual leave were difficult to manage. One staff member said, "Because we are so low numbers anyway, as soon as someone goes off sick or whatever, you really feel it". Several staff commented that staff were pulled from other units at particular times which left those units low on staff numbers. One staff member said, "The staffing [on this unit] was recently put up to four. We can manage with four but today there's only three so charts are not filled out". Another member of staff told us, "Sometimes it's quick, sometimes it's rushed, but they do get the care they need". One member of staff was observed to stay two hours after the end of their shift to try and complete admin tasks they had not had time to do. A recognised dependency tool was used to establish how many staff were needed but many staff questioned the accuracy of this and our observation was that staffing was not adequate in all areas of the service.

At times there was a lack of strategy with regard to the deployment of staff. On the nursing unit we saw that the nurse was occupied administering medication whilst also being called upon to contend with requests for help from people who used the service, telephone calls to GPs and requests for advice and guidance from staff from other units. This had the effect of delaying the completion of the drugs round considerably.

We noted that the drug round on the nursing unit started at 08.20 and finished at 11.00. On another unit the 08.00 drug round ended at 11.35. This created a potential risk of people receiving their next prescribed medicines too soon after having been given their previous dose.

Agency staff were used to fill vacant hours and we saw that there was a commitment to trying to use staff who were familiar with people's needs. We spoke with some agency staff who were regularly employed at the service and found they knew people well and could respond quickly to their needs. However, we also saw some problems with the reliance on agency staff. For example one person described how they had been unnerved the previous night when an agency nurse had not been introduced to them and they had seen them walking around the service. They said, "I saw her three times and she kept asking me if I was alright. In the end I asked her if I could help her. It turned out she was a nurse".

Relatives, although very positive about individual staff, also shared concerns about staffing levels. One told us, "I check [my relative's] toothbrush every day. Often they have not cleaned [their] teeth. I know because it's dry…..I know they're understaffed and some of these are little things but it makes a big difference".

At the end of our inspection visit a relative asked to speak with us. They were visibly distressed. They told us that their relative had been incontinent and had been waiting over half an hour to be attended to as staff were too busy. We found that the person's call bell had been unplugged. Their relative told us, "It was not in reach or plugged in". The nurse on duty was busy administering medicines and a care assistant was supporting someone with their personal care. The nurse apologised and told us that there were not enough staff. They then stopped administering people's medicines and proceeded to help the person who had been incontinent. The relative explained, "The staff are caring but there is not enough of them and this is what happens".

This demonstrated a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff employed at the service had been through a robust recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. Interviews took place to establish if staff had the skills and qualities needed to carry out the role safely and effectively.

We noted a mixed picture with regard to medicines with some good and some poor practice in different areas of the service. Before our inspection took place the local authority had raised an organisational safeguard related to the poor management of medicines on the nursing unit. Since their visit the service had put an action plan in place to address the various concerns. We saw that medicines were managed more successfully on this unit than on others. However we noted that controlled drugs and paracetamol were left unattended on a desk in the lounge area of the nursing unit. This placed people, especially those living with dementia, at risk. There was no storage facility for controlled drugs on the nursing unit and staff had to collect them from another unit.

The service had begun to convert a bathroom into a treatment room which created a lack of clear process regarding the storage and administration of medicines on the nursing unit. We found that medication administration record (MAR) charts were not stored alongside the drugs trollies and temperature sensitive medicines were held on an adjacent unit as there were no facilities for refrigerated medicines on the nursing unit. All these factors, alongside the storage of controlled drugs on another unit, contributed to the delay in completing the drugs round and staff told us they found the situation stressful.

We found that there were good processes in place when a medication error was made and staff were reassessed following the error to ensure they were competent. Medication files on the nursing unit were comprehensive and contained clear information to guide staff. Reducing balances of stock had been introduced recently in order to identify any errors more promptly and this was working well.

We had some significant concerns relating to the management of medicines on one of the units. We found that the treatment room was disorganised and unhygienic with dirty worktops and rusty drawer handles. We noted single-use syringes soaking in a pot. Staff were not able to tell us why this was taking place and the manager destroyed them immediately. Considerable stocks of medicines in blister packs and packets, including diazepam, were discarded next to overflowing bins or on the worktop. Staff told us that these medicines were going to be taken away for disposal but records of this were not accurate. The service was using a new system for disposal of out of date or no longer required medicines but some staff had continued to use the old system. Medicines, including controlled drugs, had been disposed of incorrectly in a destruction kit as the manufacturer's instructions had not been followed.

We found that MAR charts on this unit contained the appropriate information to guide staff and had been filled out accurately in most cases. There were protocols in place for when people had medicines occasionally rather than consistently. However these had not always been followed. We saw that one person's protocol for a medicine to relieve constipation stated that if the person had not had a bowel movement for three days they should report this to a carer. Records documented that there were several occasions when this had happened, including one where the person had had no bowel movement for nine days but no action had been taken and the GP had not been contacted or the medicine increased to its strongest dose.

We saw that one person had a pre-filled syringe prescribed for them and their care plan stated it should be administered in the event of an epileptic seizure. We noted that the prescribed dose was actually for half of the syringe contents to be administered. We asked senior staff about this and they were not aware. They told us they would give the person the entire contents of the syringe. We asked if the person had had a seizure which required this drug to be administered and staff said they had not. Records indicated that the person had recently had a seizure but the medicine had not been administered. This contradicted the care plan. The poor management of this person's medicine placed them at risk.

A person who used the service told us that their iron tablets and blood thinning medicine had run out and they had not received them for three days. Staff confirmed this and explained that there had been a problem co-ordinating with the local GP service. We accepted that the service had been placed in a difficult situation with regard to the confusion about filling a new prescription for these medicines but the responsibility to ensure these medicines were available remained with the service. Failure to ensure prescribed medicines were available for use placed the person at serious risk of a deterioration in their health.

This demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that risks, such as those related to moving and handling, prevention of pressure sores, choking and a person's risk of falling, had been assessed and actions to reduce these risks were very well documented in care plans. Risk assessments reflected people's current needs and were subject to regular review. One relative shared a concern with us regarding their relative's risk of choking which they felt had not been well managed. They told us, "They do not have systems in place to keep my [relative] safe". We shared this information with the manager who was already aware of the concerns and had already spoken with the relative. We left the matter with the manager for further action.

However we did note some instances where care plans had not been followed. For example one person had been placed on 30 minute observations but these had not been carried out for over six hours. Another person was supposed to be repositioned every two hours to reduce the likelihood of developing a pressure sore. This was clearly documented in their care plan but there was no record of them being repositioned from 10.30 until the time we observed them at 15.30. This was also the case for five other people who required regular repositioning. Despite the provision of pressure relieving mattresses and cushions, this lack of recording meant we could not be fully assured that all actions were being taken to reduce the risk of people developing pressure sores.

People's risk of falling was well managed. Equipment, such as sensor mats, to alert staff that a person at high risk of falling had got out of bed, were in place for some people. People's risk of falling was assessed and reviewed regularly. Falls were analysed each month to try to detect any patterns or trends to see if any further measures were needed to reduce the number of falls. We observed staff working safely according to people's moving and handling care plans.

Risks from the environment had been assessed and measures put in place to reduce these risks. Fire detecting and fire-fighting equipment was regularly checked and serviced. Hoists and lifts were maintained and a health and safety audit was in place. Water tests were carried out to ensure the water temperature did not pose a risk and the risk of legionella bacteria had been assessed and actions taken to reduce the risk. We noted that one of the suction machines was stored on the floor with the nozzle unprotected which was not hygienic and posed a risk of infection. Staff told us they were unable to store the machine in the treatment room as it was not yet ready and had no electrical supply as it was being converted from a bathroom.

Infection control was well managed with staff, including domestic staff demonstrating a good understanding of how to keep people safe by limiting the risk and spread of infection.

Staff, other than those most recently employed, had received training in safeguarding people from abuse and systems were in place to try to reduce the risk of abuse. Staff were able to tell us what they would do if they suspected or witnessed abuse and information was displayed in staff areas to guide them. Staff were aware of the service's whistle blowing policy and told us they would raise a concern about unsafe practice if they witnessed it. The service had reported safeguarding concerns appropriately and had notified CQC of any safeguarding concerns they were dealing with. We saw evidence of recent occasions when the service had been proactive in raising concerns in order to keep people safe.

Requires Improvement

Is the service effective?

Our findings

People were mostly positive about the skills and expertise of the staff. One person who used the service said, "The staff are very kind here, never grumpy when you think they're a bit understaffed. From what I've seen, I think the staff know the residents". A relative commented, "The care [my relative] gets is mostly very good and the carers are lovely. They know [my relative] and do a difficult job well". Many people living at the service were living with some degree of dementia. Staff had received dementia training and some further experiential dementia training was planned. We noted some excellent skills demonstrated by some staff when interacting with people living with dementia. We also saw some poor practice which demonstrated a poor understanding of dementia, such as people being rushed and raised voices used.

When first employed staff undertook a comprehensive induction which was designed to ensure they had the required skills and competences to carry out their roles. We reviewed staff files, and confirmed that each person had received a structured induction, checks on their competency and supervision sessions. Competency checks had been carried out by the manager and included observations of staff helping a person to eat, transferring a person from a chair, serving meals, helping someone to wash and to use the toilet and making a bed correctly. Formal supervisions were held regularly and an annual appraisal system was in operation. Agency staff received an induction before working unsupervised.

Care staff received relevant training including training in nutrition, moving and handling people, diabetes and food hygiene. We noted, however, that there was no record of people receiving further training in end of life care and mental health conditions although this did form part of their induction. Only two staff members had completed training related to pressure care and most staff either did not have first aid or basic life support training or refresher training was overdue. Staff had not had specific training in the administration of buccal midazolam which one person had prescribed for when they had an epileptic seizure. A senior staff member said, "We've had no training about it". Training was a mixture of e learning and face to face training which was popular with staff and gave them the opportunity to ask questions and deepen their knowledge and understanding.

Nursing staff were positive about the frequency and quality of their training and told us they felt well supported and able to develop their skills. Staff were confident in the use of syringe drivers to deliver medicines continuously under the skin. Staff told us that other specific training, such as PEG (percutaneous enteral gastronomy, where liquid nutrition is supplied directly to the stomach via a tube) had been provided. We noted good knowledge of pressure care and good technique providing one person with their food via a PEG feed.

Staff on the other units worked in partnership with the district nursing service and we spoke with a district nurse who was visiting the service on the day of the inspection. They fed back to us that they got good support from the care staff at the service and felt the skills of the staff helped their patients progress well between district nursing visits.

We observed staff asking for people's consent before providing them with care and treatment. People's

capacity to consent to aspects of their care and treatment was documented in some care plans and but not in others and few care plans that we saw had been signed by the person they concerned. One care plan contained very clear information about the person's capacity to make decisions and their rights but plans were not always person centred and information was generic.

We found that there was some confusion about MCA and DoLS and staff were not sure who had an authorised DoLS in place. Records did not always clarify this and some added to the confusion. One person's care plan had a section titled 'Deprivation of Liberty' but it documented a capacity assessment having been done relating to the person being occasionally unwilling to receive personal care support saying '[Resident] won't wash or shower for days. [Resident] does have a DoLS about this'. This indicates a lack of understanding on the part of the member of staff who wrote the care plan and those who have subsequently reviewed it.

Although staff had been provided with appropriate training in MCA and DoLS we found that senior staff were not clear about who had a DoLS in place, with one staff member saying they thought everybody had one. We could not be fully assured from this that people's liberty was only being lawfully restricted when authorised by the local authority.

Care plans made people's wishes clear with regard to whether they wished to be resuscitated should they suffer a cardiac arrest. Appropriate DNACPR orders (do not attempt cardio pulmonary resuscitation) were in place for people who wanted this and we saw that these had accompanied people to hospital when they had required a hospital admission.

People who used the service were mostly very happy with the food and the choice available. One typical comment was, "The food here is very good, it's delicious". Another person told us, "The other day lunch really didn't appeal to me and I asked for a salad sandwich. They made it for me and it was lovely". Relatives echoed this praise and some of them told us they had eaten meals at the service and rated the food highly. One person said, "I come and have lunch quite often. If you don't like what's on the menu, if you ask early enough, you can order something different".

The lunchtime experience differed on the various units. Lunchtime on the nursing unit and one other unit went well and we observed people receiving support to eat their meals and to make choices about their meals. Pureed food was attractively presented and staff were proactive in ensuring people had enough to eat and drink. We observed numerous caring interactions as staff supported people to eat and the impression in the main dining room was of a busy and sociable place with lots of chatter. People who chose to eat in their rooms received their meals and any support they needed in a reasonable timeframe.

Food and fluid records were mostly well completed but occasionally these had been completed by staff who had not been involved in supporting that person and we could not be sure that records were always entirely accurate. This was also the case on one other unit where people went downstairs to eat their meal. One person's food chart had not been filled out and it was clear that they had been helped to eat their lunch by an agency worker who had since gone home. This meant there was no accurate record of this person's food intake

The lunchtime experience was not so successful on one of the other units where people were living with dementia. Staff appeared to be task focussed and people were not supported to make a choice about what they ate. We heard a staff member say, "Would you like mashed potato?" and the person replied, "I don't know what that is". The staff member put it on their plate anyway rather than showing them what it was. Dummy plates, where the day's choices were plated up for people to look at, were not used to help people

decide what they fancied to eat and no finger foods were provided, although we observed one person eating their meal with their fingers.

People's weights were well monitored and unplanned weight loss was referred appropriately to a dietician or speech and language therapist for advice and guidance.

Staff demonstrated skills and expertise in supporting and caring for people and were knowledgeable about people's care needs and current health conditions. Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls team, psychiatrists, opticians, occupational therapists, dieticians and chiropodists. People told us staff responded quickly to their healthcare needs. We noted that when a concern was identified with a person's health the service took prompt action to refer the concerns to the GP or other healthcare professional. The manager told us they had arranged a meeting with a local GP service to improve communication and achieve a better working relationship between the two services.

Requires Improvement

Is the service caring?

Our findings

People who use the service, and their relatives, were mostly very happy with the way staff provided care and support. One person said, "They are lovely and friendly here". A relative commented, "The staff are very good. They are all so caring". We saw numerous examples of staff demonstrating patience and kindness whilst supporting people and relatives were keen to share with us how kind and patient they found the staff overall. However some people did raise concerns about a lack of respect. One person said of a particular member of staff, "[They] don't take time" and told us they did not feel treated as an individual. We observed this member of staff pushing the person's wheelchair very fast. They had much more positive feedback about other staff, describing one as, "Someone with kindness that can understand your problem".

We observed staff, including some of the regular agency staff, treating people with kindness and sharing a joke with them which we saw was greatly welcomed. One member of staff was observed to spend time encouraging a person to eat, getting down to their level and speaking softly in a kind manner. Care plans contained specific guidance for staff about how to reassure people if they became distressed and strategies to distract people and help them focus on something more positive.

Information in care plans was detailed and contained a one page profile which set out what was important to the person and how best to successfully support them. The profile included a section on what people liked and admired about the person. The profile of one person living with dementia documented that they liked to help staff and we saw that they helped wash and refill the water jugs and put them in the dining rooms and other similar tasks. It was acknowledged that this gave them a sense of purpose and was good for their self-esteem.

We also observed less caring practice on one of the units and people were not consistently treated with dignity and respect. One person, who called out to staff very frequently, was heard to ask to go to the toilet. Staff responded "I said ok". The person felt they were being rude and the staff response was, "Are you rude to us? You are rude to us! I'd have more respect for you if you tried". This was a totally unacceptable response. Although it was clear that the person placed very heavy demands on the staff they did not deserve such a response. We observed that they were treated in this way on more than one occasion. Staff told us they found the person stressful and we found that effective strategies were not in place to always meet the person's needs in a professional and respectful manner.

We asked people if staff respected their privacy and their personal space. Most people confirmed that staff were respectful about knocking and waiting before being invited into the person's room, although one person said this did not happen always. They said, "They don't knock but I don't mind". People told us they felt reasonably involved in planning their own care and felt they had a voice. Care plans clearly reflected people's wishes and preferences and contained life histories which we found staff to be familiar with. People who used the service had the opportunity to provide feedback on their care at their reviews and in response to feedback surveys which were carried out in the first few weeks after a person was admitted to the service.

Requires Improvement

Is the service responsive?

Our findings

We saw that people's care and support needs were comprehensively assessed before they moved into the service to ensure the service could meet their needs. A care plan was drawn up once they moved in and people's feedback on their care was sought within the first few weeks. People who used the service, or their relatives, had mostly been involved in continuing to develop their care plans and plans reflected how people wished to receive their care and support. A one page profile gave agency staff and new staff a quick overview of a person's individual needs.

We found that plans included detailed guidance about how to support and care for people and that plans were regularly reviewed by the manager and senior staff. Information on how to support people who were at the service for a respite stay was well documented and gave staff an overview of people's individual needs. Sometimes however, information was not as clear as it could have been. For example one person's care plan relating to their mobility and personal care stated they needed 'one or two carers'. The plan also stated that the person was to be repositioned every two hours but elsewhere in the plan stated they were independently mobile. The role for staff was not entirely clear.

The nursing unit was occupied by people with differing care needs, some with nursing needs and some without but who required specialist dementia care. Staff told us this distinction made it more difficult for the unit to function well and meant that, within the same unit, some nursing needs were met by the service's own registered nurses and others by the district nursing service. Staff felt that this distinction caused some confusion and meant that the unit staff were very stretched, even when the unit was fully staffed and this was also our observation.

Elsewhere we found a slightly mixed picture with regard to people having the choice to have their needs met by either a male or a female member of staff. One person told us, "I asked to have only female carers help me with personal care and that is what I get". However another person's relative told us, "I don't think it's right that two male carers look after my [relative's] personal needs. We have asked that, where possible, she has at least one female carer but we know sometimes that isn't possible".

People were supported to follow their faith if they chose this and local links to places of worship were established. One person told us they attended services every fortnight and enjoyed this.

People's experience throughout the day differed between the units. We found that some people were very positive about how they were supported to follow their own interests and hobbies. Regular activities were provided over a seven day period for people in the downstairs lounge including arts and crafts sessions, coffee mornings, exercise classes, word searches, puzzles and visiting entertainers. People also told us that there were regular outings to local places of interest such as garden centres and they enjoyed this very much.

People were brought down from other units to join in activities in the downstairs lounge but we saw little one to one provision for those people who remained in bed or whose dementia prevented them taking part

in the sessions downstairs. However we did observe a member of staff visiting a person who was being cared for in bed and spend time doing their nails which they really appreciated. The time was used for a relaxed chat and it was clear that the relationship between the staff member and the person was good.

There were limited activities such as puzzles or sensory equipment on the unit where people were living with dementia. We observed a member of staff put the television on without asking the person sitting in the lounge if they wanted this. We asked them if they liked television and they replied, "No". We also saw staff on one unit bringing socks for people to match up but this was not responded to positively.

People who used the service were issued with a charter of rights which gave people clear information about their rights so that they could be clear in their expectations of the service. There were opportunities for people who used the service and their relatives to attend meetings to provide feedback but people were not positive about these, saying they were not well structured, had no agenda or minutes and did not follow up on issues discussed at previous meetings. However we did see that there was a document called 'What you told us and what we did' but some people might not have been aware of this. Feedback surveys had been carried out with relatives and an appropriate action plan had been put in place to address any issues that had been raised. However we saw that most feedback was positive on a variety of topics.

Within the charter of rights was information about people's right to complain and we saw that a complaints policy and procedure was in place. People told us they were aware of the complaints procedure and some told us that they had raised issues informally and the matter had been resolved. One relative said, "There was a time, a few months ago, when my [relative] was not getting [their] inhaler. I mentioned it and it got resolved". Another person was happy with the way a maintenance issue had been sorted out quickly. One relative was less happy about a lock and alarm on their relative's room. They said, "It should always be locked when my [relative] is downstairs, it's in [their] care plan. The trouble is, sometimes I have come back and found the door unlocked and the alarm off".

The service had received three formal complaints since the current manager had come into post in October 2016 and each had been very well managed. We saw that each had been responded to in writing at each stage and prompt action taken to address the issue. Responses demonstrated an open and person centred approach and issues were shared with staff at supervisions and daily meetings. Seemingly minor issues were given appropriate consideration and not dismissed. For example one relative raised an issue about personal possessions not being put back in their correct place after cleaning. It was acknowledged that this could cause stress, the matter discussed at a staff meeting and the opportunity taken to learn lessons to avoid similar issues in the future.

Requires Improvement

Is the service well-led?

Our findings

The service was without a registered manager and had had five changes of manager in five years and a recent staff turnover in key posts. Staff told us they felt the regular changes of management and systems meant that they saw little point in raising issues as the likelihood was that things would change soon anyway. The acting manager had been brought in to improve the service, provide stability and manage it on a temporary basis until a new manager could be appointed. A new manager was due to start in the next few weeks and work alongside the current manager during a handover period.

The instability of the management team had had a clear effect on those who used the service and staff. One person who used the service said, "We've had 17 managers in the past six and a half years, all these changes mean there's not teamwork". Others made similar comments such as, "Deep down there are good staff here but the lead managers are not working as a team". A staff member stated, "The management team are constantly at each other's throats. And this comes down on the staff". Another said, "We've had dips in the past but this is the worst it's ever been". However we also found staff who were supportive of the manager's approach and found the management team to be supportive of them in their roles. The manager told us that they also felt well supported by the organisation and their line manager visited the service on the day of our inspection.

We found that the current manager had introduced many excellent management tools and had demonstrated some innovative practice. We noted that the manager's own relatives had been admitted for a respite stay at the service and had provided honest, and positive, feedback about the care and treatment provided. The manager had seen this as an opportunity to learn from a new perspective. The manager was to be commended for this and for their determination to raise standards and tackle difficult issues.

Clinical meetings were held once a week as well as daily flash meetings with senior staff. These meetings were designed to enable the manager to get a quick overview of current concerns and share pertinent information with staff and promote a person centred approach.

However some fundamental issues had not been effectively addressed. The manager had introduced a lot of changes but some staff had not felt consulted or listened to and many were demotivated. Within the staff team we observed that there were groups of staff working to their own agenda and the manager did not have clear oversight or control of this, despite their efforts to address issues. One major issue, which several nursing and support staff shared with us, was the decision to open a nursing unit before all required elements such as a functioning treatment room were in place and to do away with the nurses' office. Relationships in various parts of the service were difficult and we noted a lack of mutual respect which made it difficult for all members of the team to work cohesively.

It was evident that the manager had responded quickly and well to recent safeguarding issues related to medicines management but lessons learned needed to be similarly applied to other areas of the service where medicines management placed people at risk.

Information systems were not easy for staff to use. The electronic records often proved difficult to log into which did not promote accurate and timely record keeping. We asked to log into the system at 15.15 but staff were unable to log on until 15.51 due to a systems issue. Staff told us this was a frequent issue. We also noted the same thing at 17.00 when it took staff nearly 10 minutes to try to log on to enter information. The manager told us that plans were in place to replace the current system but did not have a date for this yet. Staff records and recruitment information was well organised and promptly made available to us. Electronic records, when they could be accessed, were good but some written records, such as food and fluid charts, welfare checks and 30 minute observations were not always filled in and it was not clear who audited this.

There was a comprehensive system of audits to monitor the safety and quality of the service, although recent audits had not identified all the issues we noted during our inspection or matters related to the safeguarding concerns raised by Essex County Council. Where audits had identified issues we saw that sometimes the actions required were not specific enough and led to confusion on the part of the staff. For example, a recent audit had identified that when people from other units came down to take part in activities staffing would need to be redeployed but it did not give guidance as to how. The action plan stated 'residents attending will need supervision from a colleague from the units'. We found that staff were not clear about how many of them should go down to support activities and they did not understand if this related to numbers of people attending or the level of people's individual needs.

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 The provider failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. Regulation 18 (1).