Care Quality Commission

Runwood Homes Limited

Loganberry Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 the 22 and 29 November 2016 and was unannounced.

Loganberry Lodge is registered to provide care and support for up to 138 people, some of whom live with a diagnosis of dementia. Care was provided across four units in the main building and a separate unit called Huckleberry located adjacent to the main building. There were 132 people in residence when we inspected.

The service had a registered 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 2008 and associated Regulations about how the service is run.

People spoke positively about the staff but told us that they were not always available in sufficient numbers when they needed them. Our observations were that staffing levels were not sufficient and this meant that people did not always receive personalised care or that risks were well managed.

The systems in place to mitigate risks to individuals from choking, falls and moving and handling did not work effectively and needed strengthening. Medication was not consistently well managed so for example, people were not always receiving creams and lotions that they were prescribed.

Safeguarding was understood by staff and we saw that the manager followed the procedure when concerns were raised. There were clear arrangements in place to check on staff suitability as part of the recruitment process.

People's nutritional needs were not always well managed. There was a lack of organisation and oversight which meant that people did not always receive the help and support they needed. Guidance regarding supporting people with their dietary needs were not always followed.

Training did not equip staff with the knowledge they needed to work safely and effectively. Key pieces of legislation such as the Mental Capacity Act was not always understood by staff and put into practice. Some of the restrictions which were in place around the environment were not always the least restrictive.

Staff had good relationships with those they supported and worked hard however they had limited time to spend with people. There were care plans in place but they were not always up to date and this meant that staff were not all working in a consistent way and people did not always receive the care they needed.

Activity staff were enthusiastic and provided people with regular activities which promoted their wellbeing. This was one of the strengths of the service.

Overall we found a service of contradictions where there were examples of good practice alongside poor

care. There was a lack of consistency throughout the service and audits were not effective as they were not identifying or addressing these issues. The management was stretched and the two deputy managers were not working on a supernumerary basis which meant they were not able to provide the leadership that was needed.

We identified a number of breaches of regulation and you can see what action we told the provider to take at the back of the full version of the 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? This service was not safe. Risks to people's welfare were not always managed effectively. Staffing levels were not sufficient to meet the needs of people living in the service Medicine administration did not always follow professional guidance. Staff were aware of what was abuse and the procedures to follow	**Inadequate**
Is the service effective? This service was not always effective. People were positive about the meals provided but people who required additional support did not always receive it. People were not consistently supported by staff with the right skills and knowledge. The principles of the Mental Capacity Act were not well understood. People had access to healthcare support.	**Requires Improvement**
Is the service caring? The service was not always caring Staff were kind but care delivery was task focused, and did not always meet individual needs. People did not always have choice and control over their day to day life. People were supported to maintain relationships with friends and family and their privacy was promoted.	**Requires Improvement**

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care and their needs were not consistently monitored.

Care plans were not always up to date and staff were not always familiar with the contents.

Activities were available which enhanced people's wellbeing.

There were systems in place to investigate and respond to complaints.

Is the service well-led?

Requires Improvement

This service was not always well-led.

Leadership at the service was not effective

Audits did not address the inconsistencies in care delivery and promote individualised care.

Risk analysis was not robust.

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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 started on 22 November 2016 and was unannounced. It was initially planned to focus on one area however we made a decision to complete a further comprehensive inspection and returned on the 29 November 2016. The inspection was carried out by four inspectors, a specialist advisor and an expert by experience. Our specialist adviser was a nurse with expertise in end of life care and wound care. The expert by experience had experience of health care and supporting older people.

Prior to our inspection we reviewed information we held about the service. This included any safeguarding referrals and statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law.
The provider had completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the quality team at Essex County Council who were present on one of the days of our inspection.

We spoke with twenty two people living in the service, seventeen visitors and sixteen members of staff. We spoke with the management team which included the registered manager and regional management staff. We reviewed care and support plans, medication administration records, recruitment files, staffing rotas and records relating to the quality and safety monitoring of the service.

Inadequate

Is the service safe?

Our findings

People were positive about staff, describing them as, "quite nice" and "alright". However they expressed concerns about the availability of staff. One person said, Most of the time they look after me but you do have to wait a while if you want anything, they are so busy." Another person said, "I feel safe because if I ask someone will guide me into the lounge."

Risks were not well managed. There were risk assessments in place but we found a number of these were out of date and they did not take account of peoples changing needs. They did not provide sufficient detail to staff on how the risk should be managed. For example, one of the people whose care we looked at had been assessed as low risk of choking but when we looked at their care we found that this had changed and they were now in receipt of thickened fluids to reduce the risk of aspiration. However there was no guidance to staff on how much thickener they should use to ensure the right consistency. There was no guidance on the optimum position when assisting this individual with food and drink, to lessen the risk of choking and aspiration. Another individual diagnosed with diabetes, and had recently experienced an episode where they became hypoglycaemic (also known as hypos) a complication of diabetes which occurs when glucose levels in the blood are too low to provide enough energy for the body. Symptoms can include a pounding heart, trembling, hunger, difficulty concentrating and blurred vision. We found there was no guidance about how this person's blood sugars should be monitored, the signs and symptoms of hypoglycaemia and what action staff should take in response.

People were at risk of falling from hoist slings because staff were not always clear how they should be used. People had not all been individually assessed for a specific size of sling suitable for their needs. Care plans stated that people required minimal assistance but when we checked their needs had changed significantly and the plans had not been updated and the risks to their safety when mobilising considered. For example, one of the people whose care we looked at needed a hoist to mobilise but when we looked at the risk assessments and care plan it stated that they walked with a walking frame. There was no moving and handling plan to guide staff in the equipment that they should use which placed this individual at risk of unsafe care. We spoke to staff about the equipment that they used and they told us that they used a general sling rather than a sling which took account of their specific needs and appropriate to their weight. We discussed this with senior staff who told us that a new sling had been ordered but also said they did not have time to put it into use. When we asked staff how they were going to use the loops on the sling they did not know. This had to potential to put people at risk of harm.

This is a Breach of Regulation 12(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk because falls prevention systems were not effective. We looked at the records of individuals who had been identified as having a number of falls. The risk assessments and care plans were not detailed and stated 'check regularly' or 'needing one to one supervision,' but we could not see that this was always happening. Assessments were not linked to other risks. For example where a person had a cognitive impairment or high numbers of medications including sedatives which could increase the risk of

falls. We observed one of the people who had been identified as being at high risk walking up and down corridors wearing very poorly fitting footwear. Staff were not always visible and not all the individuals had their walking frame when they mobilised.

There were good systems in place to monitor people following a falling incident. For example we saw that staff checked on people for twenty four hours after the fall to ensure that there were no complications. We saw that some people had been referred to the falls prevention service for specialist advice to prevent further falls. However, this advice was not always followed.

The provider arranged for regular health and safety audits to be undertaken but we could not see that they had identified all the risks that we identified on areas such as moving and handling. During the inspection we spoke to the manager about some of the risks that we had identified in the dementia units including a concern about a child of a member of staff on site who was unsupervised and we were told were waiting on their parent to finish work.

The systems in place for the oversight of equipment and management of environmental risks were effective. We saw that checks were undertaken on fire safety equipment to ensure that it was safe to use and staff were clear about the process to follow in an emergency. There were systems in place to reduce the likelihood of legionella and checks were undertaken on hoist slings and lifting equipment to make sure that they were safe to use and not faulty . Records were maintained of gas safety checks and the lift was regularly serviced. We saw that people who had been identified as at risk of acquiring pressure ulcers had pressure relieving equipment such as specialist mattresses in place. The settings that the equipment should be maintained at to promote skin integrity were checked to make sure that they were working effectively.

Staffing levels were not always sufficient to meet the needs of the people resident. People told us that there was not enough staff. One person said, "I do feel safe here, but you have to wait your turn if you press the buzzer." Another person said, "I do feel safe most of the time, but then when you have to wait for your buzzer to be answered I do worry." A number of relatives also expressed concern, one said, "My [relative] often has to wait for the toilet when using the buzzer and then will wet themselves by the time they come." Another told us, "They, [the staff] are always really busy." And expressed concern about the impact of this on their relative and said that they did not always receive as much help as they needed with their personal care. They told us that with encouragement they felt they would cooperate.

Our observations were that there was not sufficient staff to meet people's needs. We observed staff repeatedly trying to bring people back into the lounges who were walking in the corridor as staff were not available to walk with them and a member of staff was available in the lounge area. We observed people struggling to eat their meals and there was not sufficient staff available to support them. For example on the first day of our inspection we observed lunch on one of the units which supported people living with dementia. Staff were busy trying to support people who were trying to leave the table, wanting to walk up and down the corridor, serve meals, and support people in their rooms to eat their meal. Some people's meal sat in front of them for up to 40 minutes, untouched, other people struggled to eat what was in front of them and ate very little. Staff were juggling different demands and so focused on completion of the meal service that they did not notice that some people were not offered pudding. We raised our concerns with the manager and on the second day of the inspection additional, activity staff were deployed in this unit to support people.

Most staff told us that there were not enough staff at times. They told us that on occasion they struggled to meet people's needs and had to ask people to wait for support. There were three staff and a Care Team Manager on each unit but these staff were not always available. The Care Team Manager got involved in

other duties such as doing the medication and care staff had to have regular breaks as they generally worked long days. There was occasionally a member of staff known as a float who would support across all the units. However, staff said that this floater would often have to cover for staff absences as staff would call in sick at the last minute. When asked what impact this had on people staff said, people did not always get their baths/showers and this was borne out by the records which we examined. They also said night staff got people up earlier to help the day staff. Staff told us that problems specifically arose when people who needed two staff when using the hoist for personal care and then a third member of staff was required to be present in the communal lounge. This meant if another person required assistance they had to wait until staff were free to respond.

A member of staff raised concerns with us about staffing levels and specific events at night which we asked the manager to investigate and respond to us. We asked the manager how they determined staffing levels needed to meet people's needs. They told us that they used a dependency tool to calculate staffing levels.

The manager told us that that they would be reviewing dependency levels to check that they were correct and they had started to monitor call bell response times. The initial records showed response times was between three and six minutes

The shortfalls in staff are a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not well managed. On both days of the inspection we found tablets in people's rooms, which staff could not account for and were not aware of. We asked one individual about the tablets and they said that they thought they had been given them, "The night before last." and they were for pain. However, when we checked the medication administration record we could see no record of the medication having been administered.

This was unsafe practice, as the individual could take amounts unknown to the staff, which could result in an overdose. There were also risks to other residents who could inadvertently take this medication in error.

We observed staff administering medication and saw that they administered one person's medicine at a time, and then signed to say they had administered. We checked a sample of medication and controlled drugs and found that hey tallied with the records. Fridge and room temperature checks were being undertaken. However audits were not being undertaken on controlled drugs in line with best practice. Regular auditing ensures if there is any discrepancy this can be tracked and picked up promptly.

We saw that people had been prescribed creams and lotions but there were not always records of them having been administered. One individual had been prescribed gel for pain relief and there was a body map showing staff indicating where on the body it should be applied. However the instructions had been incorrectly transcribed and said twice rather than three times a day and there were gaps between one and two weeks where none had been administered.

The use of regular anti-inflammatory, analgesic, topical medication was part of the effective management of a person's pain relief and we could not see that it had been given as prescribed.

This is a Breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had undertaken training on how recognise signs of abuse. We saw from the records in the service that

staff had reported concerns to the homes management who had followed the appropriate procedures for reporting and investigating. We saw that disciplinary processes had been followed when issues had been identified. Staff said if they identified any abuse they would report to the team leaders and felt able to escalate concerns further if necessary. They also said they could refer to the Care Quality Commission (CQC) but none mentioned raising a safeguarding concern with the Local Authority as required. They said there was information in the staff room about safeguarding and who to contact and they confirmed they had received training.

Recruitment processes were in place to check on staff suitability and protect people. The manager told us that the provider has a specific team who undertook checks on the manager's behalf on staff recruited from abroad. Examination of three staff files confirmed that relevant checks, including ID checks, criminal records check and appropriate references had been obtained on newly appointed staff prior to them starting work.

Requires Improvement

Is the service effective?

Our findings

The feedback we received about food and our observations were contradictory. Some people's experience was good and they told us that the, "Food is lovely ."We observed that they had choice and alternatives were provided for those who did not like what was on the menu. However this was not everyone's experience and we identified that those individuals with higher needs did not receive the support that they needed. A visitor told us that they come in regularly at meal times to visit, "To encourage and cut up the food, otherwise they would not eat it."

People were at risk of poor nutrition and dehydration as the delivery of food was not well organised and people's needs were not sufficiently monitored.

Staff were not always available in sufficient numbers to support people with access to food and fluids. For example we observed that some people struggled to eat their meals and needed more encouragement and assistance. We observed on day one of our inspection that some people received a main course but not a pudding . We expressed our concerns about what we found to the management of the service and on the second day the activity staff were deployed to assist on one of the units but we continued to the same issues in other parts of the service.

People with dementia were at increased risk as they may not always recall whether they had eaten and the monitoring systems were not effective. There were records of food and fluid intake but they were not always completed accurately . We observed a member of staff completing records late morning from memory and what was being recorded was not accurate and did not correlate with our observations. We looked at a sample of records and saw that there were gaps and amounts were not being totalled so there was no overview as to what people had eaten. For example, two people deemed as at risk of losing weight we observed did not eat their midday meal, staff had recorded that they had eaten their meal.

Some people did not have jugs of juice/or water in their rooms or access to regular fluids. In a number of rooms without jugs the room had a strong odour which might suggest people were not drinking enough to maintain good health. In the communal areas people received inadequate support to regular drinks. A relative told us there were set times for drink trolleys and these had been forgotten when staff were busy. On one of the days of the inspection, the drinks trolley was still making its way around, just before lunch and we were concerned that this could impact on people's appetite. A visitor expressed concern about the late arrival of drinks and said to us, "Why would people want tea and coffee this time of day before lunch."

The home uses the malnutrition universal scoring tool (MUST) to identify people at risk of malnourishment. We saw that they had scored individuals and people at risk were being weighed fortnightly. We saw that referrals had been made to the dietician and advice had been provided although it was not always being followed.

We observed two people who had been identified as being at high risk of losing weight. We saw that specialist advice had been given such as the provision of regular high calorie snacks and cream smoothies.

We observed them being brought biscuits and when we looked at their records we could see no records of them being offered any high calorie or nutritious snacks or drinks as recommended. We saw that some people had continued to lose weight. Care plans were not sufficiently detailed and staff spoken with were not clear about this advice or people's needs. For example we identified that one person was diagnosed with diabetes. However the member of staff providing support did not know this. When we checked on the menu sheet operating between care staff and the kitchen we saw that this person was not identified on the documentation as having diabetes.

This is a Breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training did not always equip staff with the knowledge that they needed to carry out their role in key areas such as health care, moving and handling and support to people living with dementia.

A non clinical member of staff told us they dressed skin tears and left them for seven days before contacting the district nurse. They showed us the dressing that they used and told us that this was the procedure they followed unless it was a large wound. This demonstrated a lack of clinical knowledge about wound care, and could mean that a wound may not be seen, measured, photographed or assessed for a number of days. In this time, under the dressing, it could become infected, skin could react to the dressing or the wound deteriorate. Similarly a member of staff told us that when there were issues with a catheter such as bypassing. They told us, "We wait for 24 hours before calling the District Nurses." This was poor management of the catheter, if the catheter is blocked and it is left for 24 hours without being either replaced or flushed through it can cause pain and discomfort to the person due to the bladder being distended.

Staff told us that people shared slings which put people at risk of cross infection and injury. Staff were not aware of the risk associated with moving people using the wrong size sling. We asked one member of staff how they would ascertain what size to use and they told us that they would guess.

We saw that staff were not always aware of how to support people with dementia and particularly those who exhibit distressed behaviours. For example a carer referred to people with dementia as often shouting and walking about without recognising the reasons for people's distress. Staff told us they just work as a team and 'just manage each situation.' Staff told us that the dementia training provided lasted a couple of hours. Staff said this training did not provide de-escalation techniques which they said would be helpful as they cared for people who regularly became distressed and would bite and punch staff. There was a dementia specialist who occasionally visited the service and staff said they could ask for strategies to meet people's needs.

We saw that there was matrix which identified the mandatory training which staff were expected to complete. We saw that training was provided on a range of areas including safeguarding, moving and handling and fire safety. Staff told us that they were able to undertake additional qualifications such as the qualification credit framework. However the majority of training provided was e-learning. Staff said they had to do this at home as there was not time during their working day. We asked the provider about the systems that were in place to ensure that e-learning training had been carried out by the member of staff themselves and not others, but they were unable to provide this assurance.

This is a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they were provided with one to one supervisions which enabled them reflect on their practice. The manager told us that a senior member of staff observed senior staff administering medication to ensure that they were competent. They were planning to commence a similar programme for all staff on moving and handling.

CQC is required by law to monitor the operation of the Deprivation of liberty (DoLS) and the Mental Capacity Act 2005 (MCA) which provides legal safeguarding for people who may be unable to make decisions about their care. We found the principles of the legislation was not well understood although the manager and staff told us that they had undertaken training about protecting people's rights. For example when we asked a senior member of staff about how many people had a DoLs in place they told us they were not sure and spoke about people self-funding their care. This did not reassure us that staff understood their roles and responsibilities with regards to The Mental Capacity Act 2005.

The manager told us that they had made applications as required to the local safeguarding authority on behalf of people where their freedom of movement had been restricted, to ensure their best interests would be assessed by those qualified to do so. However we were concerned that some of the restrictions that were in place were not always the least restrictive. For example doors between the units had codes which meant that people could not leave the units to go onto another unit. We observed a number of people trying to leave the units and some people were persistent in their efforts and became frustrated when they were prevented from doing so. We spoke to staff about this and a member of staff told us that they had been told that, "Residents are not allowed to go onto other units." We spoke to the manager to ask why the door between units were kept locked and they told us" I don't know it's always been that way ever since I have been here."

We saw that a number of people had decisions they had made recorded such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders in place which set out their wishes not to be resuscitated in the event of a cardiac arrest. These were maintained in people's care records, and there was no central log easily accessed in an emergency. We expressed concern as to how staff would be able to access this information when required urgently in an emergency. We spoke to staff about this and they told us that they had been instructed that they should commence resuscitation regardless of the DNACPR order. This meant that people's rights to express their wishes as to whether or not to be resuscitated had been discounted and their human rights not upheld.

People had access to health care support when they needed it. We saw evidence of referrals to a range of health professionals such as the speech and language service, GPs and chiropodists. The service had set up regular meetings with the nurse practitioner from one of the local surgeries to improve communication and build on existing relationships.

Requires Improvement

Is the service caring?

Our findings

People spoke about staff in a warm way and clearly had good rapport with them. They told us that most of the staff were kind but that they did not always have time to spend with them. People were protective of staff and told us that the issues at the service were due to staffing numbers rather than the dedication of staff. One person said "It's not their fault they don't have the time." One person said, "The staff do not have time to talk to you, they are so busy." Another person said , "Staff are kind and considerate…they become like your family."

We observed some good interactions between staff and people living in the service, such as a comforting arm when a person became upset. However the interactions were largely limited to the completion of a task such as handing out meals or drinks. Staff did not have time to sit and talk with people for any meaningful period and we observed that they were busy with other duties such as competing records and doing the washing up. A relative told us, "The staff do not really come and talk to the Residents.

There were two activity staff who worked in the communal areas and we saw that they were kind and sensitive in their approach. However there were only two of them working across the five units and there were not enough of them to ensure that people were socially stimulated, particularly those individuals who spent the majority of their time in their rooms. The manager told us that they were recruiting additional staff.

There was a 'keyworker' system in place; this linked people using the service to a named staff member who had responsibilities for overseeing aspects of their care and support. This worked better in some parts of the home than others. Where it worked well people were able to tell us who their key worker was.

We observed that staff were courteous and spoke to people in a respectful way. But we also observed misunderstanding as some of the staff had strong accents and people asked them to repeat things several times. One person said, "Some of the staff you cannot understand."
One staff member with limited understanding of the English language, apologised for their difficulty in understanding our questions which had to be repeated a number of times until they understood. One person spoke about the different nationalities of carers and told us, "I feel as I am going round the world … and there are language problems but we get by."

The provider had systems in place to involve people in decision making about their care such as reviews, residents meeting and questionnaires. These worked to varying degrees and we saw minutes of meetings and the results of questionnaires. The manager was able to tell us how they had responded and showed us the action points. However our observations on the specialist dementia units were that people did not always have a lot of control or choice over their life. For example we observed people trying to leave the communal areas but being redirected back to these areas. Staff were not available to support people to walk around as they told us that they had to stay in the communal areas.

People told us that their privacy and dignity was promoted. One person said, "The staff will always close the

curtains when they are going to wash me." People were supported to maintain relationships with friends and family. People's relatives and those acting on their behalf visited at any time and told us that they were made to feel welcome. One person told us, "I can have visitors whenever I want, and I have made friends here."

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care and support and their needs were not consistently monitored. We saw that while some people looked well-groomed other people did not. We checked the records to see how often people were being offered baths and showers and saw that some people were not being offered or were receiving these on a regular basis in accordance with their plan of care. Where care plans recorded people's preferences to have a weekly bath or shower we found gaps in excess of four weeks and a number of people's names were not included in the bath list which staff used to provide oversight of scheduling. We asked staff about this and they could not explain this but told us that if they were short of staff, people did not get baths or showers.

People's needs were not always fully documented in the care plan and the information was not all up to date. This meant that staff did not always receive clear direction or guidance on how to meet people's needs. For example information was not included about what continence aids peoples needed. A number of people had a diagnosis of dementia but the care plan did not describe how this impacted on them and their needs as a result of this diagnosis. We found that some people's needs had changed significantly but their care plan had not been updated. For example one person who had lost a significant amount of weight did not have a nutritional care in place to guide staff as to what action they should take to provide to mitigate the risks of malnutrition.

The monitoring of peoples bowel movements was ineffective and did not protect people from the health and wellbeing risks associated with this. For example we found that a number of people where the recording of bowel movements was inconsistent and there were large gaps of up to three weeks. Some people were prescribed laxatives as and when required to help them but we could not see how staff were monitoring bowel movements and making an effective judgement as to when this medication was needed.

People had a "This is my life " document on the front of their care plans which asked people a series of questions about things that worried them and how to support them when they are anxious. We found a significant number of these had not been completed and were blank.

Peoples references were not always documented for example whether they had a preference for a male or female carers and we saw on some units there were a high number of male staff and there was not always a clear choice. Information was not included about people's care needs during the night time period. For example, what time people liked to go to bed or how to promote a good night's sleep. We were told that some people were assisted to get up early in the morning and we were not clear if this was always their choice.

People did not always receive care in line with their care plans and it was not clear if this was because there was an issue with the plan being out of date or the staff not being aware of the contents. For example one of the care plans we looked at stated that an individual had two hearing aids but they were wearing only one. A relative expressed concern that staff were not following the recommended guidance about positioning of their relative. Staff we spoke with were not fully aware of the contents of care plans. One staff member

stated, "I don't get involved with the care plan and risk assessment paperwork, it is the senior that does that"

Some staff had a limited understanding of risk assessment documentation and were unable to state what was in them. One member of staff told us, "I think there are risk assessments in the care plan but I am not sure." Another member of staff said, "Only the senior deals with the paperwork." We observed that staff did not have easy access to care planning documentation as they were locked and staff had to wait until the senior was available and could unlock the door.

Care plans were supplemented by records in people's rooms which included repositioning records which staff signed when they repositioned those individuals at risk of pressure damage. We saw that handovers were undertaken at key points in a day to ensure that information was handed over between staff.

Regular activities were provided in the communal areas which supported people to follow interests which promoted their wellbeing. One person told us, "The activity man is very good he does so much." Another person said, "I love going to the gentleman's club." People told us that there were a range of activities on offer which they liked to participate in such as armchair exercises and racing. On the day of our visit we observed a reminiscence activity and a man's group. People were positive about the activities and our observations were that people enjoyed them. The activity staff were enthusiastic and clearly dedicated but activities on offer were limited by their availability. The manager told us that they had recruited to the vacant activity staff posts. The manager told us that the service had recently won awards for their activity provision and aimed to make every day interesting and active.

People and their relatives told us that their concerns were investigated. One relative told us that they complained to the manager and, "She did sort it out." There was a complaints procedure in place for people to use to raise concerns which referred people to the regional manager, the local authority and CQC. We looked at the records of complaints and saw that concerns had been investigated and where shortfalls were found apologies were given.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives gave us contradictory feedback about the service. Some people were positive but others expressed concern. One relative said, "Some of the staff are friendly but if I had the money I would move my [relative]. I am not thrilled with the care here." "Another said, "It is early days yet but so far we are happy with the care provided. It is not one of the plushest places but for what we can afford we have no complaints."

Quality systems were in place but were not effective as they had not identified key issues in the service. We spoke to the manager about how they assured themselves that the service delivered high quality person centred care. They showed us some of the data that they collected on a monthly basis which included weight monitoring, details of pressure damage and numbers of falls. We saw that the data had identified that some people were losing weight and that there was a plan documented. For one individual, for example we saw that it stated that they should be encouraged to have homemade milk shakes. Another individuals plan stated "continue with cream shots and provide snacks." However when we checked the records on these individuals we saw that this plan was not being implemented consistently by staff. Similarly with falls, information was collected on individuals who fell which identified the location and the times. However we found that there was significant under reporting and a number of the people we looked at were not listed as having fallen although we saw from the records that they had. This meant that the oversight systems were ineffective.

The manager told us that they under took a daily walk around the service and checked on the quality of care and deployment of staff. We looked at the records of these visits and saw that there was more of a focus on environmental issues. For example the audit looked at whether there were any odours and whether call bells were in place. We saw records of night visits and other audits by area managers which included a review of the dining room experience. However the audits were all relatively positive and did not identify some of the key issues that we found at the inspection around the organisation of meals and staffing . The provider also organised for an external company to undertake a compliance visit report and there was an action plan in place in relation to this.

Surveys to ascertain people views were undertaken on a regular basis and this was confirmed by relatives we spoke with.

The lack of effective oversight is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not evidence a positive, empowering culture where the needs of people were a priority. The culture of the service was task focused with a lack of consideration of current best practice in meeting the need of people living with dementia. For example, the institutionalised locking of doors without considering how to prevent this restriction of people's movement from one dementia unit to another. Staffing levels were not always appropriate for the level of support required and did not take account of people's needs for

social stimulation and interaction. The staff team appeared to work hard but had limited time to provide good quality, interactive and responsive care.

Leadership at the service was not effective and there was insufficient management oversight and governance. The manager was not visible and significant number of the people and relatives we spoke with did not know the manager. Staff said that the manager was rarely seen on the units except when carrying out their checks. The deputy managers were not supernumerary and worked as seniors on one or other of the units for the majority of their working week. One of them we spoke with told us that that they should be fifty percent working on the floor with staff and the remainder of their time on a supernumerary basis. However this had not happened consistently because of annual leave and staffing shortfalls We spoke to the manager about this and they said this was because they were covering staff vacancies. This meant that the lack of management oversight contributed to the shortfalls that we identified at the inspection.

Staff told us that the care team leaders and deputies were approachable and would assist staff when needed. Staff told us they got regular support around their care practices, including supervision and appraisals. They told us there was a champion of the month, where people using the service could nominate a member of staff who they believed worked to high standards and went above what was expected of them. We also saw and were told about staff who went over and beyond what was expected of them, for example one family spoke in glowing terms about a carer who was their relative's link worker. They said he consulted with them and kept them updated as to any changes in the health and wellbeing of their relative. However these good practices were not consistent across the service and we spoke to other relatives who had not been invited to any care reviews and had not seen their relative's care plan.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication was not always being managed in a safe way The risks to people's health and safety were not always being managed effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Peoples nutritional needs were not being consistently met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems to monitor and improve the quality and safety of service were not working effectively

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably competent and skilled staff were not always available to support people