Care Quality Commission

Tamaris Healthcare (England) Limited

Howdon Care Centre

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

This focused inspection of Howdon Care Centre took place on 21and 30 November 2017. It was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

We carried out an unannounced comprehensive inspection of this service on 30 November and 1 December 2016 and found the provider was meeting the fundamental standards of relevant regulations. At that time we rated Howdon Care Centre as 'Good' overall and 'Good' in all five domains. After that inspection we received concerns in relation to staff ability to support people who had compromised gag reflexes. As a result we undertook this focused inspection to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Howdon Care Centre on our website at www.cqc.org,uk

Howdon Care Centre is a 'care home'. People in care homes receive accommodation, nursing and personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Howdon Care Centre accommodates up to 90 people across four separate units, each of which have separate adapted facilities. Two of the units specialise in providing care to people living with dementia and one provides general nursing care. At the time of this inspection 88 people were in receipt of care from the service.

The home has not had a registered manager since September 2017. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had recruited a new manager at the end of September 2017.

Although they had been reviewing the service and making changes we saw little evidence of good governance or leadership. We found the manager was not able to discuss confirm to us the needs of people who used the service or accurately described the layout of the service.

We found that there were insufficient staff employed and deployed at the service to ensure people's needs were met. The provider used a dependency tool but this did not take into account the size and layout of the

service, which was in effect four 20+ place homes. Thus staff were working in teams of three to five care staff with senior staff covering two units. We found staff were unable to meet people's needs.

We identified a number of concerns around the management of health and safety risks such as appropriately supporting people who required adapted diets and individuals who were at risk of falls. The provider had been alerted to these concerns during recent safeguarding investigations. In response to this they had had organised a full range of training and supervision around supporting people who have compromised gag reflex to eat.

However, on the first day of the visit we observed staff not adhering to care plans for instance, giving people food that had not been fork-mashed, when they required their food to be of this consistency. Following the first day of the inspection the provider ensured action was taken to rectify this and the cooks sent adapted meals to units, which were identified for each person who required these meals. Also we found there were insufficient tables and chairs on each unit to ensure all of the people could eat in dining rooms and no adapted plates and cutlery were being used, which led to people struggling to consume their meal. Albeit drink dispensers were located in each lounge, these either did not have any glasses or people could not independently reach them. Staff's ability to spend time in the lounges was very limited so people were not offered drinks other than at set times. We found that staff needed to improve the accuracy of their recording when monitoring peoples' fluid intake.

We found from the review of records that some people displayed behaviours that challenged but staff had not received training to deal with their behaviours safely and the actions they needed to take were not detailed in the care records.

Copious care plans were in place and often these were inaccurate. A lack of assessment tool led to staff being unable to record people's needs and highlight any changes. Care plans were undated, staff did not evaluate how successful or determine the accuracy of them. The regional manager and manager accepted this was a gap. They told us the provider was in the process of reviewing the documentation and considering how to improve the assessment of people's needs.

Maintenance checks of the building and equipment were completed, but the quality assurance systems had not picked up on the issues we noted in relation to the upkeep of the building, cleanliness and adherence to infection control procedures. On the first day of inspection we pointed out various issues with the up keep of the home, such as door locks being broken and mattresses being ripped. The regional managers ensured these were addressed and continued to review the service to identify the improvements that were needed.

Although staff understood the requirements of the MCA and DoLS authorisations, we found that records associated with this were not always clear.

Accidents and incidents were monitored, but we found improvements were needed around how the information was analysed and used. Also staff needed to review how they stored medicines and ensure the guidance for administering 'as required' medicines was clear. We found that in general medicines were administered in line with prescriptions but found the information in care records was incorrect.

Effective recruitment and selection procedures were undertaken before staff began work to ensure people's safety. Safeguarding and whistleblowing procedures were in place. However the provider needed to ensure staff received regular training and supervision.

Following the inspection we wrote to the provider and asked them to put measures in place to address

these issues and to supply us with a detailed action plan outlining the steps they intended to take in response to our concerns.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, meeting people's nutritional needs, staffing and having good governance systems in place. We also identified that the service had not informed us that they were accepting younger adults who had learning disability and people living with a physical disability. You can see what action we told the registered 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?

Requires Improvement

The service was not always safe.

The provider had not ensured staff were trained to support people who presented with behaviours that challenge.

There were insufficient staff deployed at the service to meet people's needs.

Staff needed to improve the practices around administrating medicines.

The service was not always clean or well maintained.

Staff were knowledgeable in recognising signs of potential abuse and reported any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff adhered to the requirements of the MCA but the documents for staff to use to complete capacity assessments needed to be improved. Also the DoLS authorisation records had only been obtained since the manager took up post.

Action was being taken to ensure staff received a wide range of training on manual handling and nutrition.

People needed to be supported better to ensure they received a nutritional diet.

Staff sought input into people's care from healthcare professionals when needed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not ensured the systems for assessing and monitoring the performance of the service were effective which

placed people at risk.

The regional managers were taking action to improve the operation of the service but further work was needed.

Although the manager had been reviewing the service we saw little evidence of good governance or leadership

There was no registered manager at the service.

Care Quality Commission

Howdon Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We carried out an unannounced comprehensive inspection of this service on 30 November and 1 December 2016 and found the provider was meeting the fundamental standards of relevant regulations. At that time we rated Howdon Care Centre as 'Good' overall and 'Good' in all five domains. After that inspection we received concerns in relation to staff ability to support people who had compromised gag reflexes. As a result we undertook this focused inspection on 21 and 30 November 2017 to look into those concerns. The inspection was unannounced. The inspection team consisted of an adult social care inspector, a bank inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to our inspection we considered all of the information we held about the service within the Commission, which included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales.

We also contacted external healthcare professionals and the placing authority commissioners to gain their views of the service provided at the service. We also attended local safeguarding meetings around an incident that had occurred at the service in advance of our visit.

During the inspection we spoke with 19 people who used the service and three relatives. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot communicate with us.

We spoke with two regional quality managers, the manager, the deputy manager, the clinical lead, human

resource training staff, a CHAP (Care Home Assistant Practitioner), two senior care staff members, 11 care staff, an activity coordinator, the cook, and a domestic staff member. We looked at ten care plans and medication administration records (MARs). We also looked at recruitment records and the records related to the overall management and operation of the service.

Requires Improvement

Our findings

We saw two bathrooms, one on unit two and one on unit four, being used as storage areas for several wheelchairs and other items such as hoists and moving and handling slings. The bathroom was unlocked and therefore a potential risk to frail elderly people who may trip over these stored items. We found a number of toilet seats were loose in people's en-suite facilities and in one person's bedroom the covering at the base of the radiator was hanging loose. We also saw the frame of a shower seat was cracked and therefore a potential hazard and a door dividing two people's bedrooms was unlocked and could be easily opened knocking the top of one person's bed which was situated in front of it. We discussed these issues with the regional quality managers on the first day of the inspection and they were rectified by our second visit to the service.

We saw appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. This exposed people, staff and visitors to the possibility of catching a health care associated infection. For example, in a number of bedrooms we found pressure mats, used to alert staff if a person gets out of bed during the night, were heavily stained with dirt and debris. In five bedrooms we saw that, although the beds had been made, the sheets were stained. We also found that some of the plastic covering on mattresses placed on the floors to prevent harm to elderly people should they fall out of bed, were also stained and had not been cleaned effectively. We found the plastic covering on the bed rail covers in two bedrooms were ripped as was the covering on a chair in one person's bedroom. We discussed these issues with the regional quality managers on the first day of the inspection and they were rectified by our second visit to the service.

We observed on both days that staff needed to leave communal areas unattended for long periods of time, despite there being people sitting in these areas who were attempting to get out of chairs when they were unsteady on their feet and could not to do so safely.

The provider had not identified that there were insufficient call alarms in communal areas. For instance, in one lounge there was only one call alarm, which was hung behind the television. This meant no one could reach it. Also, we observed that not all of the people who remained in their bedrooms had call alarm pads to hand, which meant they could not readily alert staff.

We found the provider needed to ensure their analysis of accidents and incidents covered the broader picture for people, so, for example, reasons as to why someone was experiencing an increase in falls at specific times could be reviewed. We found that a lack of review meant the provider had not ensured there were adequate staff available to support people at high risk of falls.

We spent time in all the units and checked 17 people's bedrooms. In one of these bedrooms, where people were living with advanced dementia type illnesses, we found Hydromol ointment (prescribed for the management of eczema) with an instruction to 'avoid eyes'. The bedroom was unlocked and we saw one person with dementia walking along corridors trying doors. The provider had not recognised that there was a risk some people may inadvertently ingest something that could cause them harm due to their illness.

We found that in general medicines were administered in lines with prescriptions but found the information in care records was incorrect and the 'as required' protocols did not provide sufficient information about why and when these medicines should be given.

We did not see evidence of Personal Emergency Evacuation Plans (PEEPs) in individual's care records and staff could not accurately tell us how many people resided on each unit. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

We noted that people had limited access to their walking aides and spent large parts of their day sat in their chairs. Staff did not encourage people to mobilise.

Albeit drinks dispensers were available in the lounges these either had no glasses or people could not physically get to them. When staff were giving people drinks of tea they placed them out of reach and this led to people having to get up to get their drinks. We observed that one person had sustained a black eye and saw they were very unsteady when getting up to get their drink. Whilst people were having these drinks none of the staff remained in the lounge to support the person.

This is a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were insufficient staff available to safely meet people's care needs.

On the first day of the inspection we were told there were two nurses, a CHAP, a senior care staff members and 16 care staff on duty during the day, and two nurses and nine care staff on duty overnight. The following week at our second visit we were told that during the day there were two nurses, a CHAP, a senior staff member and 13 care staff on duty. The manager believed no changes had occurred in the staffing levels but did not realise the figures showed three less staff were on duty.

The service is divided into four completely separate units, which can each accommodate 20 to 25 people. The provider had a staffing tool called CHESS, which they used to calculate staffing levels. We found this tool had not taken into consideration the layout of the building and its unitisation, or the complexity of people's needs on different units. We found that typically three care staff were available on each unit, as the staff in charge were busy overseeing two units.

We were told by the manager there was meant to be one senior care staff member plus four care staff for 25 people living on 'Unit two'. We spoke to the senior care staff member on this unit who told us that the senior care staff member allocated to 'Unit two' was also responsible for 'Unit one' on the ground floor and worked between both floors. The CHAP confirmed their duties included giving medication, checking the diary for GP and hospital appointments and making arrangements for people to attend these. They told us they were responsible for administering medicines in the different units to those people who did not require nursing care. This meant when the CHAP was on the other unit administering medicines, this left only three care staff to meet people's needs on 'Unit two'. At least three of the people on this unit required two to one support

with their care needs, and there was one person who required one-to-one support at all times.

We saw at times throughout the inspection on all units there were no staff visible or available to supervise people in communal areas. All of the staff we spoke with during the course of the inspection said they were concerned about staffing levels and some said they were leaving the service to find alternative employment because of this shortage of staff. A staff member said, "There is a massive problem with staff. We work five/six days in a row and twelve hour shifts. Lots of staff are refusing additional shifts because they are too tired. Today we have two appointments that means a member of care staff is out of the building. There have been lots of mix ups with the rota and sometimes there are two seniors on duty and sometimes none. This has meant the CHAP from another unit has had to come over to give medication."

On the second day of the inspection the manager told us there were four care staff and one senior care staff member was allocated to 'Unit two'. We were told by various staff that due to short notice sickness on 'Unit one', one of the care staff from 'Unit two' had been asked to cover that shortfall. This meant there were only three care staff and one senior care staff member on 'Unit two'. During the inspection we saw this was insufficient to meet people's needs. For example, one person had been given their breakfast in bed and when lunch was being served after 12pm we found this person asleep with their breakfast still in front of them. We later found out that the member of care staff who was asked to cover the staff shortage on another unit was undergoing their induction training and was not an experienced member of staff familiar with the care needs of people.

We asked care staff on 'Unit two' how they made sure one-to-one support was provided for one person who was assessed as requiring this level of support. We were told by various staff that when they arrived on shift the person in charge delegated this to a staff member. They told us because of staffing difficulties it was difficult to provide this and at times they had to work around staff shortages. Staff told us that a staff member would be allocated to sit with the person for the full duration of the time. The manager told us that at weekends the person went home to visit their relatives but staff informed us that this was not the case. From the rotas we could not determine who was allocated this role or if sufficient staff were on duty over the weekend to meet this contractual obligation.

A relative told us, "I don't think there is enough staff. In the last 23 days, [person's name] has only had three showers. Sometimes they go eight days between showers. [Person's name] writes down when they have a shower in their diary." Another relative told us, "[Person's name] needs two staff to move them now. When they go to the toilet, or goes to bed or the dining room, two people have to be there. There are not always enough staff around to watch them and see if they need help".
One person commented, "Not enough staff at the minute. They just keep leaving. I've been here two years and it's got worse in the last few weeks."

This is a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe. One person said, "Staff are good to me." Another person told us, "I feel safe here. Staff look after me well here. They help me get ready for bed every night." Another person said, "Oh yes, I feel safe. It's a nice place here." A relative told us, "Yes it is very safe here indeed. Staff are very aware of safety."

Staff understood what actions they would need to take if they had any safeguarding concerns. Safeguarding and whistleblowing policies were in place.

We confirmed that the necessary checks of the building and equipment were carried out. These checks helped to protect the health and safety of the people using the service. However, we found that all areas of the service were in need of refurbishment. The regional quality managers ensured the issues that we pointed out to them during our visit were addressed immediately.

We found that the bed linen, duvets, towels and the tabards (used at mealtime) were worn and some had holes in them. The regional quality managers undertook to replace all of the worn items.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions. We confirmed that the provider had completed checks with the Nursing and Midwifery Council (NMC) for qualified nurses to ensure they remained registered to practice.

Requires Improvement

Our findings

People's needs were not always met because there were not enough staff on duty. We saw that staff could not promptly respond to any indications that people were experiencing problems. In one person's care records it stated, 'There is a risk that [name of person] will become more distressed without adequate response from staff to help her feel safe.' We saw this person was often ignored by staff walking by as they were too busy attending to other care tasks.

Staff were not always knowledgeable about the care and support people received and they had not always received the training they needed to support people effectively and safely. They told us they did not have time to look at the care records. The fact the offices where the records were kept were locked and only senior staff had access to them compounded their difficulty. We observed staff did not follow instructions about individual's care as a result and this caused people to be put at risk especially around nutritional support and the management of falls. We found that the provider had recently organised a full range of training and supervision around supporting people who have compromised gag reflex to eat. The staff we spoke with confirmed they had been provided with training which included moving and handling and food hygiene. We saw that training was underway in relation to dysphasia.

The regional quality managers told us that some staff had completed dementia specific training. However, we could not evidence during our inspection how the dementia specific training or dysphasia training had been put into practice by staff.

Although a number of people used the service who could become very distressed and display behaviours that may challenge, none of the staff had received training around how to meet these people's needs. From discussions with staff we found they were not able to explain how to prevent and manage people who may become agitated and challenge the service. There was no step by step guidance to inform staff about what they should do to support people in a positive way at such times. We asked staff what they did when people became agitated and they said, "Keep them in their room."

We found that staff had not been provided with any further specialist training to meet the needs of the people in their care, for example, people with a learning disability or people with epilepsy.

This is a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about the food. One person said, "I don't like the meals." Another person said, "The food is alright, you get what you are given." Another person told us, "I like the food, it's nice and there's enough of it." Another person commented, "The food here is not bad at all. They feed us all the time. I have cereal and toast for breakfast, but I could have something cooked. Lunch is the main meal and we have tea and supper." Another person said, "Sometimes I don't like the food. They make me an omelette sometimes. I like the soups and sandwiches. The cakes are good too. I do get my own food. The staff come and ask me if I want anything from the shops and they get me cuppa soups or tins of oxtail soup. I often have these for meals."

Risks to people's welfare were not managed safely. For example, people at high risk of malnutrition were at risk because food and fluid charts were not being used properly to make sure people were eating and drinking enough. We saw that a nutritional booklet was used to record daily food and fluid intake. We asked staff what happened to this information once the booklet had been completed. We were shown a box and told they were placed in there until they were archived away. We saw no evidence of how this information was used effectively to monitor people's food and fluid intake. We saw that one person at high risk of losing weight, was given their meal to eat in their bedroom. Staff did not supervise what this person ate. We observed this person to put their cup on top of their plate to indicate they had had enough. We saw that much of the food had either fallen to the floor off the plate or was left on the plate. Staff told us they went round after everyone had finished their meal to complete people's food and fluid charts. We later noted that staff had recorded in this person's records that they had eaten half of their casserole mash and half of their carrots, despite the fact that the majority of the food was on the floor.

We discussed this with the regional managers and they reinforced with staff the need to ensure people were supported in the correct manner when eating and drinking. On the second day we observed that people received the correct assistance when eating and drinking.

We found that some people were losing weight but staff had not considered that the lack of support or appropriate crockery might be contributing to this loss.

We found that there was limited choice for those people who needed a soft diet and each day there was just one option. Moulds were not available for the catering staff to use to enhance the look of the pureed food and lots of people complained about the quality of the food overall. We found the staff did make referrals to dieticians and SaLT [Speech and Language Therapists] but did not chase these up if there was a delay or no response from the team. Thus one person who in February 2017 was assessed by the staff as high risk of choking had been referred to SaLT and placed on a waiting list in March 2017 but staff had not followed this up, even when the 12 week waiting times had lapsed. They only contacted the SaLT to chase this matter up 28 November 2017, which was following a review of all people with high or medium choking risks, which was prompted by an external safeguarding investigation

We found the advice and guidance given by specialists in the field of the care of Percutaneous Endoscopic Gastrostomy (PEG) feeding systems (this is a method of ensuring a person receives adequate nutritional intake if they are unable to eat or drink themselves) had not always been followed. For example, a healthcare professional had reviewed a person's care needs in relation to their PEG. We saw in the review records 'PEG site was dirty', however, there was no follow up action by staff to ensure this did not happen again. In another person's care records we saw an entry had been made on 26 November 2017 'Person continues to lose weight staff to encourage to eat and offer a fortified diet'. During lunch we saw this person was left to eat their meal alone in their bedroom with no staff support being offered. There was also no evidence that their care plans had been updated to incorporate this information. We saw that between 29 September and 19 November 2017 this person had lost 6.5 KG in weight.

This is a breach of Regulation 14 (Meeting nutritional and hydration needs) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff appropriately recognised when people had or did not have the capacity to make decisions around their everyday lives, but they would benefit from more bespoke training around how they were supposed to complete capacity assessments. Also staff needed to be able to access the MCA code of practice in order to ensure their practices were in line with expectations.

Records within the service were not easily located, sometimes incomplete and not well structured. For example, we found limited information was contained in people's care records to show that capacity assessments and 'best interests' decisions had been completed. The available capacity assessment forms did not support staff to clearly identify, which decision the person was being asked to make. The 'best interests' decision forms we saw did not encourage staff to identify who out of a multidisciplinary team had been involved in the discussion. The provider's care record template did not prompt staff to establish who had enacted lasting power of attorney for care and welfare or finance and if the Court of Protection had appointed anyone to act as an individual's deputy. Also, it did not support staff through the process for referring individuals to the Court of Protection when they objected to being subject to a DoLS authorisation.

The manager told us that the local authority supervisory body had authorised DoLS but we were not able to find all of the associated paperwork. The manager confirmed that would take action to follow up missing DoLS authorisation paperwork.

Copious care plans were in place and often were inaccurate. The lack of continuous assessment led to staff being unable to evidence how their skills and working practice had led to positive changes for people. As care plans were undated there was nowhere to reflect on and evaluate how successful or not these were and staff were not removing information about the support no longer offered.

The care plans we looked at did not reflect how to manage peoples' diverse needs. We examined the care records for one person and found that on a regular basis this person could become agitated and could 'kick and nip' care staff as well as 'bang their head off the wall.' There was no further detail about what staff should do to support this person in a positive way to help avoid this behaviour or what to do when they exhibited this behaviour in order to minimise the risks of escalation. There was no acknowledgement in the care plan that this behaviour was due to this person's learning disability nor did the care plan acknowledge their individual needs, background, life history and circumstances.

We noticed some younger people in their 30's were living in 'Unit two' with older people some of whom had dementia. We asked the manager about this and they confirmed the service accommodated a number of

people with a learning disability, but was unsure as to how many. We looked at the care records for two of the younger people and could not find any assessments of their needs to demonstrate how the care home was able to effectively meet them.

We discussed with the manager how care based assessments could be enhanced. The provider only supplied a pre-admission template and therefore following people moving to the service there were no other documents for staff to use to assess the current position. This lack of a comprehensive assessment had led staff to using care plans as the assessment tool and meant that numerous care plans were generated. The use of care plans in this manner meant the person's priority needs were lost and staff would find it difficult to readily identify when care records were updated. The regional quality managers and manager accepted this was a gap. They told us the provider was in the process of reviewing the documentation and considering how to improve the assessment of people's needs.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People told us that the staff tried to make sure the service met their needs. One person said, "Everyone here is lovely. They chat to me all the time. The cleaners always have a chat." Another person told us, "Staff do understand me. They're very good."

A relative said, "[Person's name] loves the banter from staff. [Person's name] is very cheeky to them and they all get along great!"

We saw some attention had been given to the physical environment where people living with dementia were accommodated which reflected good practice. For example, some communal toilet seats were a bright contrasting colour so that they could be easily seen. Also there was evidence of memory boxes and photographs being used to help people find their bedrooms, however, such practices were not consistent throughout the service. For example, the corridors on the first floor of the home were all a similar colour and some led to a locked door. Although we did see good clear signs of toilets so people living with dementia could easily find these areas, on the unit four, where people living with advanced dementia were accommodated, these doors were locked. We asked care staff about this and they said it was so people couldn't 'wander' into them. There was no evidence of technology being used (such as sensor lights) to aid people's independence.

We saw evidence that people had access to other health care professionals. For example; we saw doctors visiting people during the course of the inspection.

Requires Improvement

Our findings

At the time of our visit, the manager had been in post since September 2017. Although they had been reviewing the service and making changes we saw little evidence of good governance or leadership. The manager was not able to confirm to us the needs of people who used the service or accurately describe the layout of the service. On the first day they told us that the units accommodating people living with dementia were on the top floor but on the second day we were told by the manager these units were at one end of the building. The manager not always aware of who was on duty and did not realise that a care staff member on their second day of induction had been asked to work on a different unit as the third person. Also the manner in which they contracted one-to-one support for one person was not clear and the manager thought this person went home at the weekend, which they had not been doing for over a month.

The manager did not know that currently the service is accommodating younger adults with a learning disability and people with a physical disability. They were unable to provide information about the numbers of people who used the service with these conditions.

The statement of purpose and registered service user bands for this service did not indicate there was an expectation to admit the above service user groups. Also, none of the staff had received training around how to meet the needs of these people, and the environment and level of activity have not been tailored to support these people.

We found the quality assurance procedures in place lacked 'rigour' and were not robust. Although auditing and analysis was carried out, this was not always effective. For instance, we found that the CHESS staffing tool had not taken into consideration the layout of the building and its unitisation or the complexity of people's needs on different units. This had led to insufficient staff being deployed and employed at the service. The nurse and senior care staff had to oversee two units each and we observed they were routinely difficult to find and could not support staff on both units. Neither the provider's staffing tool, nor the manager, had noted this difficulty.

On the first day of the inspection there was only one domestic staff member for 'Units one and two', which were accommodating 45 people. We were told by staff that there were meant to be two domestic staff members covering these two units, but one of the domestic staff was on planned leave. No provision had been made to cater for this planned leave. This meant there was only one domestic staff member to clean 45 bedrooms as well as communal areas, bathrooms and toilets. The domestic staff member we spoke with said "I only have time to do the basics when I'm on my own." On the second day of the inspection we found

that a domestic staff member from another service was providing the cover for the person who was on planned leave and the regional managers confirmed this cover would continue.

We found the quality monitoring systems had not picked up that staff were not adhering to care plans, that there were insufficient staff to monitor people at risk of falling, that adapted plates were not being used and people were not able to eat their meals so were losing weight. The tools also did not pick up issues with the environment and that there were insufficient dining tables and chairs.

We looked at how the provider monitored and checked medicines and the care records. We found that the audits had not highlighted that there was a lack of 'as required' protocols and care records were inaccurate, lacking in detail and difficult to navigate.

Since coming into post the manager had been able to recruit new staff and a clinical lead. They intended to reconfigure the staffing structure and remove the roles of deputy manager and clinical lead. These roles were to be replaced by the introduction of two unit managers and the number of supernumerary hours these staff had, was to be reduced. It was unclear how these new roles would add benefit to the service, as the current arrangement of the clinical lead and deputy manager overseeing two units was not effective. Also it was unclear what the rationale was for this change, particularly as the clinical lead role had only recently been created.

This is a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (regulated activities) Regulations 2014

Staff morale was very low and there was a very high turnover of staff with many staff informing us during the inspection of their intention to leave. This was having an impact on staff's energy to deliver the service. The provider had recognised this issue and the human resources team had been visiting the service and set up sessions were staff could come and share their concerns. The regional quality managers were hoping that by identifying the concerns they could put measures in place to rectify them and therefore persuade staff to stay.

At present it cannot be said that the manager was able to provide the necessary oversight of the service. However, the manager told us that the provider was supportive of the action they were taking and were providing them with the resources to allow this to happen. We noted that the regional staff, the managing director, the head chef and human resources staff were providing additional support at present. We found these staff, in conjunction with the manager, were trying to resolve the problems around staff retention as well as to improve staff morale and practices.

We found that issues were raised around staff moving and handling practices the day after our first visit and prior to our return. Additional staff training had been put in place plus action had been taken to improve staff understanding of dysphasia and poor gag reflex. We found that over half of the staff had already received additional training and supervision, and this indicated that the provider was being proactive in trying to resolve issues at the service.

Staff had mixed views about the current management arrangements. Staff said, "[Manager's name] has implemented things such as only her, the clinical lead or administrator being able to alter the rota and that makes it hard to get cover." Another staff member told us, "The new manager is down on the rota to cover some shifts, as a nurse but they have too much to do in the office." Another staff member said, "I do find if you approach [manager's name] they will listen to you."

Staff told us they felt they worked hard to make sure the service was well-run. A relative said, "This home is so much better than the one [person's name] lived in before moving here."

The manager was in the process of setting up meetings with all the staff, people who used the service and relatives so they could give their views about the service.

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 Risks that people were exposed to in their daily lives and environment were not appropriately managed meaning that people's health and safety was compromised. There was a lack of information around the administration of medicines and cleanliness standards within the service were not adequately maintained. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not supported appropriately to ensure they received adequate food and fluid and their dietary needs were met. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury	The provider had not ensured the systems and processes in place to oversee the operation of the service were effective. Regulation 17 (1)

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 had not ensured that there were sufficient skilled and experienced staff employed and deployed at the service. Regulation 18 (1) (2)