The Gloucester Charities Trust

Guild House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This was an unannounced inspection which was carried out over two days on 27 and 28 October 2014. We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 relating to the Mental Capacity Act 2005, safeguarding adults from abuse, staff recruitment, staff support and in how the provider monitored the services and care provided. You can see what action we told the provider to take at the back of the full version of the report.

This service was last inspected on 3 April 2013 and at the time was meeting all the regulations assessed during the inspection.

Guild House provides care and support to predominantly older people and some who live with dementia. It can accommodate 34 people. At the time of the inspection 32 people were living at the service. Accommodation was across three floors each with its own dining room, lounge

Summary of findings

and bedrooms with personal bathrooms. A passenger lift was available to help people get to the first and second floors. People who lived with dementia were supported on the first and second floors.

At the beginning of 2014 there were two registered managers who job shared. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Although still employed by the provider, at the time of the inspection, neither manager managed the home. One had been absent from work for a long period of time and the other was now in another role within the company. In September 2014 an interim manager had been employed to manage the home.

We observed there to be enough staff with the right skills and experience to meet people's needs. Staff were aware of people's individual needs and risks. Although staff knew how to recognise abuse and report incidents or allegations of abuse within the company, their understanding of the county's wider protocol on reporting safeguarding concerns was poor. There was limited access to up to date information on this. The provider had not ensured that staff had a full and effective understanding of the safeguarding processes. Staff also lacked clear guidance on physical interventions (restraint).

Robust staff recruitment practices had not always been followed. Potentially people were at risk of being cared for by staff who were unsuitable.

People's needs were monitored well and any changes in these were effectively responded to. People were treated with dignity and respect and their privacy was maintained. People were supported to live their lives in the way they wanted to and were free to make their own decisions.

Staff supported people who lacked mental capacity to retain their life skills and to make simple day to day choices. However, these people had not always had their mental capacity assessed. Whether people were able to make decisions about their care and treatment or whether decisions needed to be made in their best interests this had not always been determined. The levels of control and supervision each person required had not been reviewed to ensure people were not unlawfully deprived of their liberty. Therefore people who lacked mental capacity had not had their rights protected under the Mental Capacity Act 2005.

People received skilful care by staff that had been trained to do this, however staff had not received effective and consistent support. This had resulted in some staff being unclear about their roles and responsibilities. Staff attitudes and competencies were checked through staff supervision and appraisals however, the consistency of this needed to be improved upon. This put people at risk of receiving inappropriate or unsafe care. The interim manager had started to provide sessions where staffs' training needs and concerns were discussed with them. Some staff had also received feedback on their performance and, where appropriate, issues with staff performance had started to be addressed. Despite this staff had maintained core values which meant people had been treated with respect, compassion and dignity.

Staff who had been responsible for providing leadership had failed to provide this effectively, despite attempts by the provider to resolve this. The interim manager had begun to provide staff with leadership and had put processes in place to start to identify shorfalls in the service but this was very much in its infancy. There had been no on-going monitoring arrangements either within the home or recorded by the provider. The provider therefore did not hold accurate information about where the shortfalls were and was unable to make the required improvements. This put people at risk of receiving care and services that were either inappropriate or unsafe.

People received care which was delivered with patience and kindness and people told us they liked the staff and felt cared for by them. People's wellbeing was important to staff who supported people in a manner that supported this. People who were important to those who live in the home were welcomed without any restrictions. Where appropriate, staff communicated with relatives or representatives about the person's health and welfare. People were provided with the privacy they wanted or required. People told us they had not always been involved in the planning or reviewing of their care but said they did feel listened to.

Summary of findings

People had access to health care professionals when needed and staff requested a review by appropriate health care professionals when people's needs required this or altered. People's choices, wishes and preferences were responded to. Care plans recorded these and gave guidance to staff about how people's needs were to be met. Some care plans did this well and others did not do this so well. Staff received verbal handovers about what care people needed which included any daily changes. Therefore, weaknesses in the care planning had not meant staff were not aware of people's needs. The interim manager had begun to identify shortfalls in the care plans and risk assessments and knew where the improvements were needed.

There were activities for people to join in, if they chose to, and people were supported to make good use of the wider community. However, there was a lack of meaningful activities for some people with dementia Better opportunities for meaningful activities were needed for some people with dementia. The provider had been aware of this and told us this would be improved.

Concerns and complaints had been listened to, responded to and investigated. However records did not always show whether proposed actions arising from a complaint had been taken and whether the complainant was satisfied with the outcome. Therefore the provider would not have enough information to know if the complaints had been managed effectively. People who live in the home knew how to make a complaint and there was information for visitors about this. The interim manager told us they maintained an open door policy and people told us they found them approachable.

People had been given opportunities to feedback their views on the services provided and how the home had been managed. Although this feedback had been acknowledged, because of the change in management, it was not possible to make a judgement about whether people's feedback had influenced how the service had been managed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe. Staff recognised abuse and knew how to report this within the company. However, their knowledge of the county's wider protocol for reporting and managing safeguarding issues was poor. Access to updated guidance and information on safeguarding adults was limited.

Staff recruitment had not always been robust and this put people at risk of being cared for by unsuitable staff.

There were enough skilled staff in number to meet people's needs although how staff were deployed needed improvement.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective. People who lacked mental capacity were not fully protected because their capacity and ability to make decisions had not always been assessed and determined.

People were looked after by staff who had not received adequate support or feedback on their practice.

Staff identified, monitored and met people's individual care and health needs.

People's nutritional risks were identified and acted on.

Is the service caring?

Good

The service was caring. People received care from staff who were patient and kind.

Staff treated people with respect and provided them with privacy when required.

Staff listened to people who live in the home and acted on what they said.

Staff were committed to the people they cared for and wanted them to have a good quality of life.

Is the service responsive?

Requires Improvement

The service was not as responsive as it should be. Activities and stimulation for people living with dementia were lacking

People's care plans did not always record all elements of their care needs, although staff received good verbal information about people's needs and alterations in their health.

People's changing needs were responded to quickly and effectively.

Summary of findings

Concerns and complaints were listened to and investigated, although records did not always contain what actions were actually taken in response.

Is the service well-led?

Inadequate

The service was not well led. Staff had not been provided with effective and consistent leadership.

Communication at all levels had resulted in staff feeling unsupported and resulted in them lacking direction.

Quality monitoring had not been effective and this had resulted in the provider not having sufficient and accurate information to be able to make improvements to the service.

Guild House

Detailed findings

Background to this inspection

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

This inspection was unannounced and was carried out on 27 and 28 October 2014. The inspection team included one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We sought information from local commissioners and health and adult social care professionals who visited the service. We sought views about the service from three of these professionals. We looked at notifications (Information that a service is required to send to us about significant events).

We spoke with 11 people who live in the home and one visitor. We looked at four people's care records, which included their care plans, assessments of risk, care monitoring charts and their medicine records. We observed how the staff supported people and spoke with them. We spoke with a representative of the provider, one of the registered managers and the interim manager appointed to manage the home. We spoke with five members of staff. We also spoke with a visiting GP. We looked at records that related to how the home was managed. This included paper and electronic recruitment records, accident and incident records, health and safety records and certificates. We looked at audit forms which had been introduced by the interim manager but not yet completed. We looked at three policies and the complaints file. We also looked at the home's registration certificate, the statement of purpose and insurance certificates.

We attended one hand-over meeting between staff members. After the inspection visit and on our request the interim manager forwarded to us the staff training records and information which related to staff recruitment and quality monitoring.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe. For example one visitor told us staff had taken action to protect their relative from another person who had walked into their bedroom at night. However, we found areas that required improvement which included staff recruitment and a limited understanding of safeguarding processes.

Previous employment history of staff and Disclosure and Barring Service checks (DBS) had not always been carried out prior to staff being employed to ensure they were suitable to work with vulnerable adults. DBS checks identify if prospective staff have a criminal record or are barred from working with vulnerable adults.

Three recruitment files were looked at and contained application forms, although, in one case the requested dates of past employment had not been completed by the applicant. The records did not show that this had been explored with the applicant or if there had been any unexplained gaps in their employment history. One reference had been obtained but there was no reference from their last employer where they had worked with vulnerable people. There was no record or checks of the person's character during their last employment or reasons why they had left.

Clearances obtained from the (DBS) had been recorded electronically. Three members of staff had no electronic record of a DBS clearance having been received. The interim manager followed this up and confirmed the provider held no additional information anywhere else about this. People were therefore put at risk of being cared for by staff who may be unsuitable. The interim manager said they would ensure appropriate clearances were obtained.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said they would report abuse or an allegation of abuse to a senior member of staff. There were flow charts around the home giving guidance to staff on how to report safeguarding concerns within the company. These also contained contact numbers for relevant external agencies. Training records showed staff had received training on this subject but their understanding of the importance of sharing safeguarding information with relevant agencies, how to contact these (despite this information being on the flow charts) and what their roles were in the safeguarding process was poor when we spoke with them. Staff had access to an out of date safeguarding adults policy and access to the up to date policy was limited as this was held electronically. Computers were in managers' offices which were locked when they were not present. Staff told us they had either not read the provider's safeguarding policy or said "It was a while ago" or "I read it ages ago." The provider's arrangements had not ensured staff had a full understanding of the safeguarding process.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people if staff were available to help them when they needed help. They confirmed staff responded quickly when they rang their call bell, day or night. One person explained they had fallen out of bed; they said, "I just slipped to the floor and was able to call for staff who came quickly and put me back in bed". Some people commented about the home changing since more people with dementia had come to live at Guild House. One person commented that staff have a "heavier load" and told us there is not so much time for them. We spoke with the staff about staffing numbers, one member of staff said, "We have enough staff when everyone is present (meaning staff members)". Other staff told us they sometimes worked with one less member of staff than they should. One member of staff said "This is fairly frequently" and another said it could be "difficult" to meet everyone's needs when this was the case. Staff confirmed that people who lived with more severe dementia were always supported by sufficient numbers of staff. Staff told us it was on the other floors that it could be difficult. The provider acknowledged there had been shortages in recent months and the Trust had communicated its appreciation to all staff. They had also advised staff of the additional recruitment taking place in order to ease the pressure on the existing care staff team.

A representative of the provider told us there were always enough staff, in total, within the home to comfortably provide care. The staff roster allowed for 7 care staff to be on duty each morning and 6 each afternoon not including the Heads of Care whose hours were largely in addition to the above. The provider's representative acknowledged there may be occasions when last minute staff sickness could not be covered but they said this was not a frequent event. They told us there were usually staff working in the home who had been allocated separate

Requires Improvement

Is the service safe?

hours to carry out management tasks or fulfil other roles. They also said people's care was a priority and they would expect these staff to help if care staff were short. They acknowledged that senior staff had been given the responsibility of managing staff rosters and deploying staff and they may require more support to do this effectively. We were told that the interim manager would provide support with this. We observed staff attending to people's needs as required. Staff did not appear rushed and took time to talk with people and offer them reassurance.

People were protected against the risks of inappropriate or unsafe administration of medicines. We saw four people receive their medicines. People received these after giving their consent and they were able to decline medicine if they felt they did not require it. If people wished to and they were assessed as safe to do so, they could administer their own medicines. Two people asked questions about their medicines and these were answered competently by the member of staff. All medicines were stored securely and a record made once administered. People were protected from medicine administration errors because the times of administration had been clearly recorded to allow for the stipulated gap between doses. A person had reacted to one of their medicines and staff had acted on this quickly by contacting the person's GP who addressed the issue.

People's risks were monitored and managed. For example, a sensor mat had been fitted in one person's bedroom so staff would be alerted if another person entered the bedroom. Other people had been assessed and provided with equipment to help them walk safely. People who were at risk of developing pressure ulcers had been monitored and an appropriate health care professional contacted for advice. Levels of risk were recorded.

We saw a "disaster recovery and business continuity plan" dated December 2013 which, included information which applied to 2014.

Requires Improvement

Is the service effective?

Our findings

We found areas that required improvement which included the assessment of people's mental capacity to make decisions, how staff were supported to carry out their role and how the use of restraint was communicated.

Staff obtained people's consent before delivering care or treatment. People were free to make decisions which related to their health and welfare. One person said, "I am very comfortable here, I have the freedom to make decisions about what I do and when." Staff training records showed staff had received training on the Mental Capacity Act 2005. We found, however, that where people had been diagnosed with a dementia their mental capacity had not always been assessed. For example, one person who had been formally diagnosed with dementia, by a Consultant, had not had their mental capacity assessed in relation to decisions about their care and treatment since receiving this diagnosis.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Where people had been assessed as lacking capacity, the form used by the staff for this purpose was not always fully completed. The section that asked staff to consider if the person was capable of making specific decisions, such as those relating to their care or treatment, had not been completed. There was a record for one person that stated a best interests meeting had been held with health care professionals. This showed that staff had taken appropriate action where a person lacked capacity to make their own decisions about their care and treatment. However, the incomplete sections showed staff were not always completing the full assessment to determine if best interests decisions were needed. A review had also not yet been completed, as required by law, to ensure people were not receiving unlawful levels of control and supervision.

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

One of the registered managers was present during the inspection. They were aware of how and when to make a referral under the Deprivation of Liberty Safeguards. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom these have been authorised by the local authority as being required to protect the person from harm. They had previously sought advice when needed and had made a DoLS referral when advised to do so by a DoLS advisor. The outcome of this referral was the person was not being deprived of their liberty and a DoLS authorisation had not been required. The interim manager was also aware of what was required if they were concerned that someone was being deprived of their liberty.

There was no specific policy on the use of physical interventions (restraint). The only reference to this was found in an old safeguarding adults policy. This stated "reasonable, minimum force can be used in an emergency". It did not go on to define what this was or give any guidance for staff in its use. A visiting health care professional confirmed staff made appropriate referrals to them when they required advice on managing people's challenging behaviour. The professional told us staff looked for the least restrictive approach. Staff told us they did not use any form of physical intervention when people presented with behaviour that could be perceived as challenging. They told us they used distraction techniques or left the person to calm down before trying to interact with them again. Such actions were recorded in one person's care plan for staff guidance. However, one member of staff told us they would not use physical intervention even if others needed to be kept safe. This comment supports the need for clear guidance on what "reasonable, minimum force can be used in an emergency" meant.

On visiting the top floor there was little evidence of any specific adaptions made to better care for people living with more advanced dementia. For example, objects that allowed for different tactile stimulation or for people to carry with them whilst walking. There was a distinct lack of colour. Colour is sometimes used to help people with dementia orientate themselves or to differentiate between objects, surfaces and areas. Some adaptions had been made such as a non heat retaining hob in the kitchen and a different system for summoning help where the noise did not impact on people. The provider had identified the need to review the environmental and care provision for those residents and was in the process of refurbishing the top floor and was working with the Trust Dementia Lead Manager to implement a fresh approach to the dementia care practices being employed by staff in this area. In addition the provider had carried out dementia care mapping in the home, the results of which were being

Is the service effective?

analysed and an action plan being drawn up. One project had started which, when finished, would provide this floor with a garden room where people could sit, relax and reminisce. Staff explained the walls would be painted in a garden scene, imitation grass would be on the floor and there would be seating.

We looked at how staff were supported to carry out their roles. Records showed staff support in the form of staff supervision sessions but these had not been as consistent as they should have been for all staff. For example, two staff still needed to receive their first one to one session and others had only received one session since April 2014. We were told staff ideally should receive a one to one support session every three months or more frequently if needed. This was being addressed by the interim manager and staff, told us they felt more supported by the interim manager.

A representative of the provider told us supervision and appraisal plans were in place for the year to March 2015. They told us the sessions held with staff were recorded on a spread sheet and an external consultant was employed to audit these on a quarterly basis & provide feedback to the home manager and the provider on the progress and the quality of the supervision notes. Nearly half the staff had received feedback on their performance. The interim manager told us they were due to carry out support sessions with some of the night staff on the night of one of the inspection days.

Although staff had been issued with job and role specific descriptions the lack of support and feedback had resulted in staff being unclear about what was expected of them. For example, one member of staff had failed to record checks they were carrying out as part of an additional role they held. In order for staff to be clear about their responsibilities and roles consistent and effective staff support needed to be consistent and sustained.

People commented that staff were well qualified and had the skills required to give good care. Comments included "Staff have the skills to do their job", "Staff here are the right people for the job; they don't just have anyone" and "All staff are well qualified and well chosen, from the top downwards; they have good skills and care is well done". Staff told us they had been provided with helpful and relevant training. Training records showed staff had received training in subjects relevant to people's needs, although training such as the safeguarding training had not increased staffs' knowledge greatly. An on-going program of update training was in place and new staff received induction training relevant to their role. The staff that provided training were trained to do so.

Eight members of staff had received additional training to help them promote good dementia care. Their role in this had not been developed or encouraged and managers told us improvements to how dementia care was delivered were needed. Despite this, one health care professional told us they thought people's dementia needs were met well. They also confirmed that their recommendations were always followed and staff attend meetings held in the county for staff who care for people with dementia.

People's day to day health needs were monitored and effectively met. Records showed that people, important to the person who lived in the home, were updated with any changes in the person's health. People had access to community health care professionals and staff had good working relationships with these professionals. The records staff maintained enabled visiting health care and adult social care professionals to assess people's current needs as well as their changing needs. One visiting GP confirmed staff referred people to them appropriately and that staff had good knowledge about the people they cared for. Equipment was sourced when needed. For example, pressure relief mattresses and cushions for the prevention of pressure ulcers. Staff confirmed that no-one had a pressure ulcer although one person's fragile skin was being monitored by the community nurse team.

People told us they enjoyed the meals and were happy with the food provided. One person had a different diet to others and they said, "I get good well cooked meals, I am never hungry". Another person said, "The food here is excellent, plenty of it. I am well catered for". People who were at risk of not eating and drinking enough were identified, care plans and risk assessments were recorded and the appropriate support provided. Staff told us people could choose where to eat but they encouraged certain people to eat in the dining room. This aimed to reduce some people's isolation, encouraged others to move and for some, enabled staff to monitor the person's intake of food more closely from a discrete distance. For example, one member of staff told us one person had been losing weight and they were monitoring them more closely. People's weight was reviewed monthly and recorded. If they started to lose weight, the frequency of weighing

Requires Improvement

Is the service effective?

moved to weekly and the person's GP was informed. Staff recognised that people with dementia were at risk of losing weight and therefore sometimes required additional calories. These were provided throughout the home through cooked breakfast options, biscuits with mid-morning drinks and cakes with mid-afternoon tea.

There were bowls of fruit in all communal lounges where people could help themselves. We observed people with dementia being provided with fruit and cake with their afternoon cups of tea. Hot drinks and sandwiches were also provided by the night staff.

Good

Is the service caring?

Our findings

People told us staff were kind towards them. One person said, “Staff are very kind and look after me well.” Another person said, “The staff are lovely, they treat me very kindly and will do anything I need, all staff are my family.” Another person said, “Staff are delightful, so kind they fall over backwards to help, they make this home from home. I get very good personal care, very dignified.”

We observed staff taking an interest in people and listening to them. Where people were able to do things for themselves we observed staff giving support in order to either promote independence or help a person to retain skills. One person said, “Staff are kind and helpful, very good indeed, even when I know they are rushed they still allow me to try to do things for myself, they want me to stay as independent for as long as I can”. We observed staff spending time with people in order to enhance their quality of life. This varied from supporting the person in an activity such as baking, chatting to them or just sitting next to them. Staff knew people well and were able to tell us what would cause a positive reaction from them and what was likely to cause upset and anxiety.

People were provided with the privacy they wanted and required. One visitor said, “Care is excellent, I am very satisfied with the care my relative is getting, they are happy too, I didn’t think they would settle as well as they have as they are a very private person; they even enjoy having their weekly bath because staff are so sensitive when it comes to things like that.”

We saw people being given the opportunity to make choices. Staff did this by listening to people and acting on what they said. People were able to talk about their options. For example, one person was not sure if they needed their medicine. The member of staff involved discussed with them the effects of taking this and the likely effects of not taking it but also verbally reminded the person that it was their decision. People who live with dementia were also supported to make simple choices. We witnessed the use of gentle direction or suggestion when it was obvious that a person was unable to make a choice or decision and where continuing to wait for the person to respond would have resulted in anxiety or embarrassment for them.

We saw information about advocacy services which meant people could access support from an independent person if they required it. The interim manager was not aware of anyone who had used this service. People told us there were no restrictions on visiting.

Requires Improvement

Is the service responsive?

Our findings

There was one full time Activities Co-ordinator who spent the majority of their 35 hours per week at Guild House along with two other Activity Assistants who spend a total of 16 hours at Guild House per week. In addition the home had adopted the "Whole Home Activities" approach. A weekly activities programme was on display. It recorded a varied range of activities some led by staff and some not. For example, volunteers from a local church organised an activity which people said was popular and usually well attended. One person was a keen gardener and was able to continue this interest in the home's garden. One person commented about the activities having been "toned down to satisfy others needs". This person said they no longer felt "intellectually stimulated".

Staff explained that people who live with dementia and who live on the top floor were welcome to join in the programmed activities but that they usually stayed on their floor. Many of the activities on the main program were not appropriate for the abilities of the people on the top floor. Staff on this floor told us they undertook activities with people when they "had time". They explained that it depended on what else needed their attention. For example, on one visit to this floor most people were asleep in the lounge and both staff were involved in reassuring one person who had become very distressed. However, at another time there were three people involved in a baking session with the help of the staff present. On another visit we saw three people asleep in the lounge and another was interacting with their doll. We did not observe many items or objects around the unit that could provide people with stimulation.

Three people confirmed they had been involved in the planning and reviewing of their care. One person said "I see it (the care plan) sometimes, I think they (the staff) have a responsibility to do that". One person's care plans had been signed by them indicating their agreement. Other people indicated they needed more support and opportunities to be involved in planning their care and reviewing it. One person felt they had not been involved enough but they could not give us further information on what they felt had been lacking or say in what way they would like to be more involved. A visitor said, "I have a recollection of the manager asking me to tell them about my relative, and the sort of things they like, but nothing formal." Despite this staff clearly knew people well including those who live with dementia. They were able to talk about people's likes, dislikes and what was important to them. Care files recorded family and representative's involvement in providing some of this information to the staff.

Some care plans lacked detail about people's needs. For example, one person spoke with us about the pain they lived with. Staff attending to this person were very aware of the person's needs related to this but this was not reflected in the person's care plans. This meant staff may not always be clear about people's care needs. Specific actions had already been taken to help this particular person. For example, with the person's consent, a move to a bedroom nearer the dining room had meant the person could walk there independently. There were also examples of detailed care plans. One person's records showed staff had closely monitored and identified a deterioration in their mental health. In response to this staff had referred the person to appropriate health care professionals. The person had been found to be living with dementia and as a result staff were directed to give more support. Records showed that this extra support had been beneficial to the person.

People were supported to maintain their interests and links with the community. Staff helped facilitate this by arranging transport, for example, to a local day centre and arranging escorts for taking people to church. On one of our inspection days we saw people boarding the mini-bus for a trip to the day centre. Many people went out with their friends and families.

We spoke with one person who wanted to remain as independent as possible. They told us a member of staff had taken them shopping for clothes. They said "I thoroughly enjoyed it and chose clothes I would never have thought would have suited me before. I felt more confident with someone with me."

The complaints procedure was available in the reception area. One person who lived in the home told us if they had a complaint they would speak to one of the senior care staff. Another said they had told the management about something they were unhappy about and this had been dealt with discreetly. Three complaints had been recorded in the complaint file for 2014. All had been initially responded to quickly. All had recorded actions to address the issues raised. One complaint had been responded to and resolved. Another had been raised in June 2014 about the effectiveness of the call bells. One member of staff

Requires Improvement

Is the service responsive?

confirmed during this inspection that the call bell system was not working properly. When we asked the interim manager about this they explained that some work was required on the system. A representative of the provider explained the call bell system had one monitor that was not working correctly during this inspection, however that this had already been addressed and they were installing a new call system which was due to be completed in November 2014. Staff had been issued with pagers which meant they were able to easily identify what room the call bell related to. Another complaint had a record of proposed actions but no record of whether these were carried out. It was not possible to tell from the records if the last two complaints had resulted in the complainants satisfaction.

Meetings were held for people who lived in the home and their representatives. The interim manager explained this was an opportunity for people to talk about what worked and what did not work, raise issues for discussion and put forward ideas. A report summarising the feedback received from relatives earlier in the year recorded that people had wanted the relative and resident meetings re-instated. This suggests that at some point these had lapsed. The interim manager told us they had held one of these meetings in September 2014 and showed us the minutes. They intended to hold these on a regular basis. The minutes to the meeting in September were on the notice board in reception.

Inadequate

Is the service well-led?

Our findings

The provider told us the service had lacked appropriate management and staff had not received suitable leadership or support. We were told by the provider that no recent quality monitoring had taken place within the home. The provider explained they had met resistance by the management team when seeking information and when trying to implement changes. In January 2014 a new management structure was introduced by the provider which enabled a job share to commence. An action plan was produced by the joint Managers which was intended to address the provider's concerns. The action plan was not implemented effectively due to unforeseen events which meant both registered managers (a job share) were unable to be present in the home on a day to day basis.

In September 2014 the provider employed an interim manager. Their task was to provide leadership, implement a quality monitoring system, report their quality monitoring findings to the provider and, with the provider's support, start making improvements to the service. The interim manager had been in the home for three weeks at the time of the inspection.

The interim manager explained that on starting they had been unable to find any previously used quality monitoring tools. To address this the interim manager had introduced several audits, many of which she still needed to complete at the time of the inspection. An audit of the kitchen however had been completed and an audit of people's care plans was in its infancy. The interim manager confirmed that a set of initial audits, which we were shown, would be completed and a report based on their findings and other information would be forwarded to the provider by 31 October 2014. The interim manager's expectation was that these audits would then form part of an annual program of quality monitoring. Actions identified by the management within the home would be recorded and completed. This would provide the provider with accurate information on what had been identified and addressed, which they could then follow up. The provider would then be in a position to identify any further shortfalls and implement improvement. The role of quality and compliance manager had recently been given to a senior member of staff employed by the trust to also help address the issues.

We were shown a report of a satisfaction survey and an externally commissioned compliance check which the provider had organised in 2013. The report had not identified any major issues and a re-visit was carried out in January 2014 to ensure the minor issues had been addressed. However the provider's own quality monitoring system had not been effective enough to identify shortfalls and implement improvements in the absence of accurate information directly from the home.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were aware of the registered managers having been absent, they were aware of the increased staff sickness and the recent need for agency staff. Problems within the home had been openly discussed and people had been made aware of the interim manager's start. People all said they would feel able to approach the deputy manager or interim manager if they had a problem or difficulty. The interim manager told us they operated an open door policy which we saw in action during the inspection. A visitor said they received written confirmation of any changes that were occurring which had included the arrival of the interim manager. The interim manager had already held a meeting for people who live in the home and their relatives and had introduced themselves.

Appraisals had taken place for 44 out of 66 staff had received appraisals since April 2014. The interim manager had carried out further appraisals since starting work in the home. The interim manager confirmed, that where appropriate, they had discussed poor performance with relevant staff and clear advice and support had been given to the staff concerned. Staff annual leave was being managed more effectively as was staff sickness. The interim manager said "this is not a bad home" and they confirmed that the majority of staff had understood and maintained a good set of values. This fitted in with evidence we had gathered which showed, whilst staff had lacked leadership, they had continued to care with compassion, strive to meet people's needs in the best possible way, show people respect and maintain people's dignity. Staff told us a lack of communication and a lack of fairness had resulted in low morale. However, they felt this was changing under the leadership of the interim manager who was actively promoting the Trust Values.

Accidents such as falls were recorded but a detailed analysis of the events leading up to a fall and the event itself had not taken place. This meant that possible trends and patterns were not being identified and used to assist

Inadequate

Is the service well-led?

staff in preventing a reoccurrence. The interim manager was addressing this by having each fall reported to them and by following the events up through further discussion with the staff.

There were arrangements in place to ensure the development and sustainability of the business. We were given information after the inspection that showed the provider held regular meetings, supervision sessions and regular appraisals of the management team. This meant the board received information about the charity's finances, current plans and future plans. We were also informed that members of the charity's board visited the home and sought the views of people who live there.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others who may be at risk were not protected against inappropriate or unsafe care and treatment because there were not effective arrangements in place to regularly assess and monitor the quality of the services provided. Regulation 10 (1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Reasonable steps were not taken to ensure people were safeguarded against abuse. Regulation 11 (1) (2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People who could not give consent for their care and treatment were not protected by arrangements provided under the Mental Capacity Act 2005. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Effective recruitment practices were not followed to ensure staff employed were of good character and that information specified in Schedule 3 was available. Regulation 21 (a)(i)(b).