Abbotts Care Centre Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Since the inspection we have been informed that the name of the service has been incorrectly spelt on the Care Quality Commissions (CQC) website and internal recording system,. The commission are in the process of correcting this error and throughout the body of the report the service is referred to by the correct name of Abbot Care Centre.

We completed an unannounced inspection of Abbot Care Centre on 3 August 2017. The service is a 117 bedded purpose built home in Harlow, Essex. The service is divided into three units all of which provide personal and nursing care for people with nursing and social care needs as well as people living with dementia. People have access to a communal lounge and dining areas on each unit and a gymnasium and courtyard garden area on the ground floor. On the day of the inspection there were 48 people living in the service.

This was the first inspection of the service since it was taken over by Excelcare in July 2016. Prior to this the service was known as Partridge Care and the provider was Rushcliffe Care Limited. The last inspection of Partridge Care took place on 5 May 2016. At this time the service was given an overall rating of requires improvement. This was because we found concerns relating to the skills and knowledge of nursing staff, a high reliance on agency staff, poor meal choices and problems with the management of medication. During this inspection we found that whilst there had been some improvements made in relation to the provision of appropriate meal choices and the management of medication the service continued to rely upon agency staff who did not always know people well.

There was not a registered manager in post. Since the previous inspection a new manager had been appointed. They were in the process of working their notice in their previous role and were due to commence employment at the service in September. In the interim the service was being supported by a regional manager and two development managers. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'; Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staffing levels across the service varied. This meant that there were not always sufficient staff available to effectively care for people and keep them safe from harm. A high reliance upon agency staff meant that people could not be assured that they were being supported by staff who knew them well. Consequently, people did not always receive care and support that was suited to their individual needs and preferences.

Potential risks to people's daily lives had been assessed. However, they were not always personalised or detailed enough to ensure that risks were minimalised and people were kept safe from harm.

Staff had completed training which provided them with the knowledge and skills to fulfil their role. However, there were some concerns about how the service monitored the skills of agency workers.

Capacity assessments and best interest meetings had taken place for some decision making. However, whilst some assessments included clear reasoning and evidence that the least restrictive option had been taken to support the person others were generic in nature and our observations indicated that the principles of the Mental Capacity Act 2005 (MCA) may not have been followed in every case.

We could not be assured that people's nutritional needs were met. Whilst staff supported people to maintain a healthy diet and to access drinks throughout the day people's meal time experience varied across the service and in some areas there were not enough staff deployed to meet people's needs at meal times.

When carrying out care staff treated people with dignity and respect. However, whilst staff were caring in their approach limitations on their time meant that the care provided was largely task focussed. People's access to activities varied across the service. Some people were supported to engage in activities which were meaningful and stimulated them however, other people were left for periods of time with little meaningful stimulation or interaction.

Staff morale was low. There was a general lack of energy and engagement among the staff which continued to impact on people's experience.

People were supported by staff who knew how to recognise the signs of abuse and who were confident about how and whom to report any concerns to.

The service had a robust recruitment process in place to ensure that staff had the necessary skills and attributes to support people using the service. New members of staff were introduced to the service through a thorough induction programme and were required to complete a probation period to ensure that they had acquired the necessary skills to care for people.

Systems were in place to record, monitor and analyse accidents and incidents and action had been taken to mitigate the risk of reoccurrence. The environment was also regularly monitored to ensure that people were kept safe from harm.

Staff supported people to take their medicines safely and staff competencies relating to the administration of medicines were regularly checked.

The management team were aware of their responsibility to send notifications as required, so that we could be made aware of how any incidents had been responded to. There were systems in place to monitor the quality of service delivered and drive improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always sufficient staff available to meet people's needs.

Risk assessments were not always personalised or detailed enough.

People were supported by staff who knew how to recognise the signs of abuse and who were confident about how and whom to report any concerns to.

There were systems in place to manage people's medicines safely.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had completed training which was relevant and provided them with the knowledge and skills to fulfil their role. However, there were concerns about how the service monitored the skills of agency workers.

Capacity assessments and best interest meetings had taken place, however some were generic in nature and our observations indicated that the principles of the Mental Capacity Act 2005 (MCA) may not have been followed in every case.

People's meal time experience varied across the service and in some areas there were not enough staff deployed to support people at meal times.

Is the service caring?

Requires Improvement

The service was not always caring.

Due to time restraints staff were task focused allowing little time for any meaningful interaction with people.

Care was not always provided in line with people's wishes or

preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's access to activities varied across the service. Some people were supported to engage in activities which were meaningful and stimulated them however, other people were left for periods of time with little meaningful stimulation or interaction.

People and their relatives knew how to complain about the service if they were dissatisfied, and how to raise any concerns or make suggestions.

Is the service well-led?

Requires Improvement

The service was not always well led.

Many of the staff had been through a great deal of upheaval and it was clear that this had impacted negatively on staff morale. There was a general lack of energy and engagement among the staff which impacted on people's experience.

The management team were aware of their responsibility to send notifications as required, so that we could be made aware of how any incidents had been responded to.

The provider had plans for the future development of the service and had tried to provide some stability to staff through the allocation of two development managers to support the service and the appointment of a new home manager.

Abbott Care Centre Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 3 August 2017 and was unannounced. The team consisted of 3 inspectors and an expert by experience who had experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we liaised with the local authority safeguarding team and attended a strategy meeting with the provider to discuss concerns relating to an increase in the number of safeguarding alerts raised about the service. We used this information to help formulate our inspection plan and looked into incidents raised during the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this and carried out observations during the inspection to ensure that they were putting this into practice. We also reviewed the information we held about the service including notifications of incidents that the provider had sent us and previous inspection reports. A notification is information about important events, which the service is required to send us by law.

During the inspection we looked at eight care plans and associated care documentation and at how medicines were managed. We also looked at ten staff files to see whether staff had been recruited safely and reviewed documentation relating to the management of the service including policies and procedures, complaints and compliments received by the service, staffing rotas covering the last six weeks, staff training records, a range of audits and the results of quality assurance surveys.

We spoke with 12 people living in the service and six visiting relatives. We also spoke with ten care workers, two nurses, the activities co-ordinator and a member of the housekeeping team and spent time with the care manager and development manager discussing the service.

A number of the people who lived in the service were living with dementia. To help us gain an understanding of people's experiences of using the service completed a Short Observational Framework for inspection (SOFI) to observe interactions between people and staff. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Abbot Care Centre. Comments included, "I do feel safe here, don't know why but I just do." And, "Oh yes I feel safe. They are all very good and look after us." However, prior to the inspection we had received a number of concerns relating to inadequate staffing and many of the people, relatives and staff that we spoke with during the inspection expressed concerns about poor staffing levels and the impact that this had on the care provided.

Staffing levels across the service varied. On Kingfisher, there were sufficient staff available to meet people's needs and we saw staff sitting and chatting with people and involving them in activities. On Moorhen however, there were insufficient staff deployed to safely meet the needs of people. Five care workers and a nurse were providing care to 19 people, 12 of whom had been assessed as needing the assistance of two staff with personal care and moving and handling. In additional another person was receiving one to one care from an agency staff member but required a second staff member to assist them with manual handling. We saw that whilst staff worked hard to support people and keep them safe there were periods during the day when people were left unattended in communal areas without the means to summon help and staff did not finish supporting people in the morning until just before lunch. We asked people whether it was their choice to get up later in the day and whilst for some people it was other people told us it was not. One person said, "I would like to get up earlier but you often have to wait as the staff are so busy of a morning, no two days are the same." Other comments included, "Staff are kind and helpful but they are understaffed." And" [The] trouble is they are so busy they cannot always answer." And, "You have to wait a long time to be got out of bed some days, because they are short staffed". We observed one person sitting in a communal area alone; they did not have access to a call bell and therefore had no means to summon help if required. After 30 minutes, a staff member brought in another person and plugged a call bell in for them. The staff member explained that the person would be able to call for help for the other person if needed.

On the day of the inspection the activity organiser remained on Moorhen. We observed them supporting people in the communal lounge area; staff told us that this had made their work load easier as usually one of the five care workers would have to remain in the lounge to support people. The management team told us that in response to feedback from staff the staffing on the unit had recently been increased to include an additional member of staff on the afternoon shift. However, staff told us that they still struggled to meet people's needs. Staff comments included, "There is no time for anything accept physical care." And, "We do not finish supporting people until lunchtime." And "We never get time to chat to people; we also have a lot of recording to do which takes up a lot of time." People living in the service also told us that they were often kept waiting for assistance, particularly in the morning, because there were not enough staff available to support them. One person told us, "I am often kept waiting to get up in the morning and it gets late". Another person said, "The staff work hard but never enough of them to help when you ring for them." We were told that staff had raised these concerns with the provider who had informed them that they were going to introduce a floating member of staff to support them during the busy periods of the day. Our observations throughout the inspection confirmed that staffing levels were not adequate to meet the needs of people and ensure us that they were kept safe from harm.

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

Throughout the service there was a heavy reliance upon agency staff and we had some concerns about the deployment of staff and how this impacted on people living in the service. One person told us, "We get agency staff and they do not always understand my needs, I sit in this lounge on my own there is no-one to talk to." Two people had been assessed as requiring one to one care. In the main this was provided by agency staff, however because they did not know people well we saw little engagement with people and often agency staff were seen simply sitting and watching people. When we spoke with the management team about our observations and the negative impact that this was having upon both people living in the service and on staff morale they informed us that they were aware of the problem and were working to address it by reviewing the provision of one to one care.

Risks to people's daily lives had been assessed in areas including; manual handling, eating and drinking, falls and skin integrity. Some care plans contained personalised risk assessments and detailed information for staff about how to support people. For example, one person had limited verbal communication skills, their care plan contained a section entitled, "Things that worry or upset me." It contained information for staff including potential trigger factors and details about how to support the person if they became upset or anxious. However, other risk assessments were generic and did not provide enough detailed information to ensure people were kept safe from harm. For example, one care plan included information about the type and make of sling that the person had been assessed as needing for safe manual handling but two other care plans just stated that the person required a hoist and sling. To ensure that staff are provided with accurate information manual handling risk assessments should outline the specific equipment needed to move a person including the type of hoist and sling; sling size and attachments. We also found that whilst risk assessments relating to the use of bed rails had been completed, on two occasions they had been incorporated into manual handling risk assessment rather than a specific risk assessment for bed rails. The inconsistency in the location of the assessment meant that it was at times difficult to locate them, this was a particular concern given the use of agency staff at the service.

Records showed that staff had attended training about safeguarding adults from abuse. All the staff that we spoke with demonstrated a good understanding of how to recognise different signs of abuse and were confident in the action that they would take to report any concerns both within the organisation and to outside agencies. One staff member said, "I would look for bruising, someone who is fearful, a change in behaviour or appetite." Another told us, "We look after vulnerable people. We need to make sure that they are safe, to look out for them and signs of abuse or mistreating and report any concerns." Staff were aware of the whistleblowing policy and explained that they were able to approach the senior staff if they were ever concerned for someone. One staff member told us, "I would tell the manager, or we have a helpline number that is external."

The service recorded and acted on incidents and accidents appropriately. Staff explained to us that the nurse would be the first point of contact unless an ambulance was required. Records were completed for each accident or incident that had occurred and included detailed information about the action taken at the time of the incident and any follow up action taken to mitigate the risk of reoccurrence.

The environment was regularly audited and risks assessed to ensure that it was safe for people to use. Water taps were fitted with thermostatic mixing valves and the temperature of the hot water was regularly checked to ensure that it was within a safe range for people to use. Nurse call bells were regularly audited to ensure that they were in good working order and legionella and gas safety certificates were up to date. Records showed that weekly fire safety checks were completed and personal electrical appliance (PAT) testing had

been carried out to ensure that electronic equipment was in safe working order.

A robust recruitment policy was in place to ensure that staff were recruited safely. We looked at the recruitment files of 10 staff members and saw that each staff member had to attend a face to face interview and all the required employment background checks, security checks and references were reviewed before they began to work for the organisation. This process ensured that the provider made safe recruitment choices. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people. Records showed that, if required, the company took staff through the disciplinary process. For example, one staff member had recorded on social media and was given a verbal warning.

There were systems in place to manage people's medicines safely. Staff confirmed and we saw evidence that only the senior staff or nurse who had been trained and assessed as competent administered people's medicines. Medicine administration records (MAR) charts had been completed correctly and there were no omissions of the staff signatures. There were appropriate facilities to store medicines that required specific storage. Medicines were safely stored and administered from lockable trolleys. People's individual medicine administration records had their photograph and name displayed so that staff could identify people correctly before giving medicines to them. People who were prescribed medicines to be used, 'As required' (PRN) had clear guidance in place to inform staff of when to use these. Temperatures of both fridges and rooms were checked daily and a stocktake of medication was completed twice a day to ensure that all PRN or loose medication reconciled. More detailed monthly medication audits were also completed and records showed that any concerns found were promptly addressed.

Our observations confirmed that appropriate infection control measures where adhered to. The service was clean and odour free throughout. Staff had access to gloves and aprons and sling hoists were used individually for each person to prevent cross infection.

Requires Improvement

Is the service effective?

Our findings

Permanent staff had access to training and had their competencies checked to ensure that they had the appropriate level of skill and knowledge to fulfil their roles. However, there was a heavy reliance upon agency staff across the service and it was unclear how the service monitored their knowledge and performance.

Records showed that staff were supported to complete training which was relevant and provided them with the knowledge and skills to fulfil their role. One staff member said, "We have a combination of e-learning and classroom training, it is all appropriate to our work. We have received additional training like syringe driver and palliative care training related to need." We reviewed the staff training matrix and saw that staff had completed a variety of training modules in areas including manual handling, communication and dignity and respect. Competency assessments had also been completed to ensure that staff understood the training and were able to apply it to their daily practise. However, we had some concerns about how the service monitored the skills of agency workers. During the inspection three agency staff were observed performing an unsafe moving and handling procedure to transfer a person from a lounge chair into a wheelchair. The staff assisted the person to stand by pulling them up from a chair under the axilla. This handling manoeuvre is no longer practised because it can lead to injuries to the person's shoulder, neck and skin damage. No clear verbal prompts were given to the person and once in standing they were transferred into a wheelchair which did not have its brakes on. Upon witnessing the procedure the development manager immediately intervened to make the person safe and addressed her concerns with the agency staff involved.

At meal times we observed that in some areas there were not enough staff deployed to support people to eat and drink. For example, on Moorhen there were six staff on duty however, at lunch time 12 people required support to eat and drink. One staff member told us, "There is not enough staff on to frequently meet people's needs at lunch time. There are a number of residents that require feeding but they often have to wait to be fed and then their dinner is cold." A person told us, "There are not enough staff to help feed some residents that need it, I am lucky can feed myself." One relative explained to us that they felt that their family member would eat better if a member of staff sat with them at meal times to encourage them. They went on to say, "Due to [relatives] dementia [they] will sometimes start to eat and then puts it down, and the food gets cold. The staff when aware will help [them] but they do not have the time to sit during the whole of her dinner time." Staff told us that they struggled with assisting people at mealtimes. One staff member said, "We are lucky that relatives help at lunchtime otherwise it would be more difficult." They went onto tell us that the provider had told them that it was okay to reheat food but they were not prepared to do that, as they knew it was not appropriate. This meant that we could not be assured that people's nutritional needs were being effectively met.

This is a breach of regulation 14 (4) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's meal time experience varied across the service. The food was of a good quality, with appropriate

choices available. People choose where they ate their meals with some choosing to eat in their own rooms whilst other people ate in the main dining area. On some of the units the dining tables were well presented with tablecloths, flowers and condiments available, however on other units this was not the case. It was not always clear how staff supported people to choose their meal. On one of the units we observed staff asking people verbally before the meal what they wanted for lunch, whilst on another unit no one was asked if they wanted the meal or given a choice of drink, it was simply placed in front of them. There was no evidence of picture menus or sample plates of food being used to support people who may have had difficulty processing verbal information. When assisting people to eat staff showed dignity and respect, sitting next to people, enabling them to set the pace and take their time. However, for many people the meal time was a sombre experience with little conversation or verbal encouragement being given. Following the inspection the provider has informed us that changes have been made to improve people's meal time experience.

Although we observed people being supported to eat and drink on the day of our visit, there was inconsistent recording of food and fluids. For example, when we checked fluid records for three people we saw that totals varied from day to day with 1800 mls recorded on one day and 400 mls on another day. Everybody had been placed on a fluid chart whether or not they had been identified as being at risk of dehydration. Consequently the charts were not consistently completed or accurate. We discussed our findings with the management team who informed us that they were in the process of reviewing this.

Some people living in the service were not consistently able to make important decisions about their care and how they lived their daily lives. 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

Staff had completed training in respect of the MCA and DoLS and understood their responsibilities under the MCA and around protecting people's rights. Staff we spoke with demonstrated an understanding of the processes to assess people's capacity to make day to day decisions and how to support people who did not have the capacity to make a decision in their best interest. Care plans we looked at confirmed that capacity assessments and best interest meetings had taken place for some decision making for example, regarding finance and medication. Some assessments included clear reasoning and evidence that the least restrictive option had been taken to support the person, however others were generic in nature and our observations indicated that the principles of the MCA may not have been followed in every case. For example, we found bedrails were in use for two people however, there was no evidence to support that a best interest decision meeting had taken place before they were put in use and that other options had been considered to ensure this was the least restrictive way to ensure people's safety. We also found that another person had been identified as not having capacity but there was no evidence of a DoLS application and where people had been assessed as having fluctuating levels of capacity this was not always clearly reflected in their capacity assessments. It was also not always clear in care plans if people had a DoLs in place or if it had expired.

Although some bedrooms were personalised with pictures and personal possessions the overall environment was not conducive to people living with dementia or those with sight impairments. On Moorhen, walls in the corridors were painted cream with white handrails and on Kingfisher the corridor was painted grey with grey handrails making them difficult for people with a cognitive or visual impairment to identify and use safely. There was no signage in corridors to support people with finding their way or orientate them to where they were. There were also no pictures on the walls in corridors or items of interest

and bedroom doors often they just had a number on them with nothing to personalise or identify whose room it was. Contrasting colours are recommended to help people with a cognitive or visual impairment define objects more clearly. For example, using coloured rubber mats and/or crockery that contrast with tablecloths helps to define the edge of plates and dishes and might be helpful for some people and toilet seats in colours that contrast with the toilet and with other nearby surfaces can help make them more visible and identifiable.

New members of staff were introduced to the service through a thorough induction programme and were required to complete a probation period to ensure that they had acquired the necessary skills to care for people.

Staff received supervision to support them in their role and identify any learning needs and opportunities for professional development. An electronic tracker was used to monitor staff supervision to ensure it was completed regularly. We looked at the tracker and saw that the majority of supervision was up to date. We looked at ten staff records and saw that staff had received a mixture of one to one supervisions and observations of practice to assess staff competencies.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, and GPs. One person told us, "They call the doctor whenever I need one." During the inspection we heard a nurse speaking with the GP about someone's medication, they gave feedback to them about how the person was getting on and updated the electronic notes. The information was highlighted as a 'message' which would come up each time a staff member logged onto the computer; this meant that staff were kept up to date about any changes. Staff had sought additional advice and support from specialists including Speech and Language Therapists (SALT) and the falls clinic and we saw that action plans had been implemented to further support people. However, we had some concerns as to whether this advice was consistently put into practice by staff. One relative whose family member required thickener in their drinks due to a choking risk told us that there had been occasions when it was unclear if this had been provided correctly. They went onto tell us that on one occasion they had found a drink in front of them with no thickener added to it, a member of staff was informed and the thickener was added. During the inspection we saw no evidence of thickener being omitted from drinks. Records showed that where people had been identified as being at risk of choking referrals had been made to SALT. Following their assessment care plans had been updated to include detailed guidance for staff including the recommended grade of fluid and consistency of their diet advised by the SALT. We saw that some people had been recommended to be placed on a pureed diet, staff were knowledgeable about the reasoning behind this and the consistency of the diet that they had been placed on.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were kind and caring but that they did not often have time to spend with them to engage in meaningful or sustained interactions. Comments from people included, "Care staff are so busy that they do not have time to talk about what you liked in your past." And, "I spend a lot of time in my bedroom, but I used to love motor bikes, no one here ever come to my room to have a chat about what I used to like doing." And, "Staff do not have time to find out what is important to you they are so busy".

Our observations of staff interactions with the people living in the home were varied. We saw that some interactions that were warm, caring and dignified. We heard staff chatting animatedly with people as brought them into the lounge and reassuring people as they passed them. One relative told us that their family member was living with dementia and staff had supported them with the use of doll therapy following the loss of a family member. Doll therapy is a resource used to reduce stress and agitation in people living with dementia. However, we also observed that some staff were task focused allowing little time for any meaningful interaction with people. For example, on Moorhen interactions in the main lounge were not sustained because staff brought people in then and then left to go and provide care to somebody else. One person told us, "The only time they can talk to you really is when you are having a wash and then some of the staff will have a laugh and joke with you." Another said, "I love to be taken into the garden in my wheelchair but staff do not have time to do that." And, "No one ever asks me about myself". One relative told us, "Despite being busy the staff are so kind and caring I cannot fault them. But they could do with more staff." A staff member told us, "We do not have time here to talk to the Residents and get to know them, it is rush, rush, rush." Another staff member said, "I would not be here if I did not love the job. Management say we have enough staff but all we do is personal care one after the other."

People did not always receive care in line with their expressed preferences and wishes. We reviewed the care records of ten people from the period of 3 July 2017 until 3 August 2017. The records evidenced that whilst people were having daily body washes they were not receiving baths or showers in line with their expressed preferences. For example, two people had requested showers three times a week, one person had only received two showers in a month and the other person had not received any during this period. We also saw that equipment was stored in some of the communal bathrooms which further suggested that they were not being regularly accessed by people.

When carrying out care staff treated people with dignity and respect. One person told us, "Staff do respect my privacy and dignity when they help me with personal care." We saw staff knocking on bedroom doors and waiting to be invited in before entering and heard staff asking for consent before providing assistance. For example, we heard one staff member asked someone, "Shall I put your napkin around you so you don't spill your food down you nice top." Another person was distressed and kept pulling at their clothes. We saw staff tactfully adjusting their clothes to preserve their modesty and giving them a soft toy to hold to distract them and reduce their anxiety.

Requires Improvement

Is the service responsive?

Our findings

We found that the care delivered was not always person-centred. Staff told us that due to time restraints care was often task focused rather than being tailored to meet people's individual needs.

Records showed that people had assessments completed before they entered the service. When the current provider had taken over the management of the service several people living there had complex needs. The management team were conscious of the high level of needs of the people currently living in the service and emphasised the importance of detailed and accurate pre-assessments to ensure that they were able to meet the needs of anyone moving into the service whilst continuing to support those already living there.

Each person had a care plan in place that was maintained on an electronic recording system. Care plans reflected people's current needs and in some areas contained some good detail of the care and support that people needed. However, in other areas the information lacked depth and detail to ensure that care was provided in accordance with people's needs and wishes. For example, one care plan stated that the person had type two diabetes but there was no guidance for staff about what symptoms to look out for in order to monitor this. Some people were living with dementia; however, their care plans did not always clearly reflect how this impacted on their daily lives.

Records showed that where appropriate family members had been involved in developing and reviewing people's care plans. Staff told us that each day a person was nominated as 'resident of the day'. They explained that this involved them reviewing the persons care plan and inviting family members to attend and input to the reviews. Staff also told us that as part of the day they spent one to one time with the person to support them in an activity, but that this depended on there being adequate staffing so was not always possible on all of the units. For example, one person had a foot spa, the hairdressing salon was used for this and staff told us they put candles in the salon and dimmed lighting. Family comments included, "I have not seen my [relative] look so happy and relaxed in ages." On the day of inspection the resident of the day was going to have their nails manicured and their hair cut. However, when we spoke with the person's relative they were not aware that their family member was the 'resident of the day' and had not been asked to review the care plan with the staff. The person's relative was however, positive about the care that their loved one received and told us, "Yes the staff are lovely some better than others but on the whole okay. The problem is they keep changing and people keep leaving."

The service had recently employed an activities co-ordinator who had been very positively received by both people living in the service and their relatives. One relative told us, "The activity lady is wonderful. My [relative] has dementia and she is taken to the lounge every day, and the lady will let her join in the colouring. Look I have come in here today and found this card she made a mark on". On the day of the inspection we saw that they were enthusiastic and engaged people in a variety of activities including craft activities and cake decorating. The interaction during the activities was positive and we heard people chatting and laughing together and staff encouraging people to participate in the activities. However, most of their time was spent on one unit which meant that people's opportunities for social and leisure pursuits varied throughout the service with some people having less opportunity for social interaction. On one of the

units staff sat with people and engaged them in various games and activities. Whilst on another unit there were no activities taking place, people were not occupied in a meaningful way and staff did not have the time to sit and talk to people. In one of the communal rooms activities were placed on tables but we did not observe anyone being encouraged to go into this room and use any of the activities. One person told us, "I sit in this small lounge, there is nothing to do except watch TV all day." We saw in one person's care plan that they liked to go to church, this person was provided with one to one care but there was no evidence that they had attended church. There was an expectation that staff would also lead on some activities, but this is not always possible because they were busy providing care to people. We also had concerns that the lack of meaningful activities for people who remained in their own rooms or who chose not to or were unable to join in group activities placed them at risk of social isolation.

People and their relatives knew how to complain about the service if they were dissatisfied, and how to raise any concerns or make suggestions. One relative told us," I have had a couple of issues here but they were sort out quickly." The service had a complaints matrix in place and we saw that where appropriate a written response and internal investigation had been completed in response to concerns raised.

Requires Improvement

Is the service well-led?

Our findings

Staff were positive about the support that they received. However, historically there had been several changes in the management structure of the service which had affected staff morale. One person told us, "We see so many different managers, think we are waiting for another one to start".

Many of the staff at the service and been through a great deal of upheaval and it was clear that this had impacted negatively on staff morale. There was a general lack of energy and engagement among the staff which continued to impact on people's experience. The dissatisfaction among staff was reflected in their response to the annual staff survey in which 44 per cent reported that they felt undervalued and 56 per cent felt that all grades of staff were not treated equally. When we spoke with the management team about this they explained that when the provider had taken over the service staff morale had been very low and staff reported feeling under constant scrutiny. They were aware that this was an area that needed to continue to work on and was not helped by the large number of agency staff at the service. Despite this in the main, staff told us that they felt well supported by the management team and described them as supportive and accessible. Comments from staff included, "I do feel supported here, and residents receive good care." And, "They are much more passionate about care and making sure that it is right." Staff told us that the development managers had an "open door" policy and were visible throughout the service.

The provider had plans for the future development of the service and had tried to provide some stability to staff through the allocation of two development managers to support the service and the appointment of a new home manager. The service was in the process of a recruitment drive and the management team were hopeful that as new permanent staff come into post staff morale would improve. A physiotherapist had also been appointed and the activities co-coordinator, who was new in post, had spent some time at one of the provider's flagship services to learn about best practice and help improve the provision of activities at the service.

There were quality assurance systems in place to monitor the service and identify areas for improvement. We saw copies of the monthly audits and reviews including medication audits, health and safety audits and weekly fire safety checks. Action plans were implemented to identify and address any issues found and records showed that concerns were resolved in a timely manner. However, we had some concerns about the effectiveness of the monitoring of the service because it had failed to identify the issues around the deployment of staff and the staff inconsistencies that we found during the inspection.

People, relatives and staff were able to provide feedback about the service to the provider through annual surveys, the results of which were collated and made available. We saw that on the whole relatives and people provided positive feedback about the care that they received. Meetings were also held for people and relatives so that they were included in the running of the service. These meetings were used to talk about any improvements taking place and give people an opportunity to express concerns. Actions required were recorded and responded to. For example, a senior weekend rota had been implemented in response to concerns raised by relatives about the lack of availability of senior staff at the weekend.

Daily management meetings provided the team with a clear oversight of what was happening across the service on that day. In addition to this regular staff and unit meetings were used to enhance communication and drive improvement in the service. The development manager told us, "Each unit is different and people have different needs so the unit meetings are important."

The management team were aware of their responsibility to send notifications as required, so that we could be made aware of how any incidents had been responded to.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs At meal times there were not always enough staff deployed to support people to eat and drink.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not adequate to meet the needs of people and ensure us that they were kept safe from harm.