Outlook Care

Foxburrow Grange

Inspection report

Ypres Road
Colchester
Essex
CO2 7NL

Tel: 01206586900
Website: www.outlookcare.org.uk

Date of inspection visit:
10 March 2017
30 March 2017
06 April 2017

Date of publication:
14 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Foxburrow Grange is registered to provide accommodation and nursing care for up to 66 older people, some of whom are living with dementia. The service is split into four units, each of which has nursing staff based on it to support people who require nursing care. On the day of the inspection there were 63 people living at the service.

The last comprehensive inspection of the service took place on 26 February 2015, at which time the service was rated as good. Following the receipt of information of concern relating to the safe care and treatment of people living at the service, person centred care, staffing levels and the management of the service a further responsive inspection took place on 21 December 2015. This inspection focused on the domains of safe and well-led and rated both areas as good.

We carried out the most recent inspection in response to concerns about the high number of safeguarding alerts raised by the service and problems highlighted by the local authority Quality Improvement and Organisational Safeguarding teams. The concerns were primarily in relation to the safe care and treatment of people using the service, insufficient staffing levels and ineffective leadership of the service.

The inspection took place across three days. The visits on 10 and 30 March 2017 were unannounced. The final inspection visit on 6 April 2017 was announced, during this visit we predominantly looked at the paperwork relating to staff files and the safety and maintenance of the service.

During the inspection we found that the provider was not meeting the legal requirements in multiple areas of the home. Following the first day of the inspection an urgent action letter was sent to the provider highlighting the concerns that we had found and requesting them to provide an action plan detailing the measures that they planned to implement in order to address these concerns. When we returned to the service for the second day of the inspection we found that the service had made some progress in addressing the concerns highlighted but continued improvements were required to ensure that people living in the service received safe, effective care from staff who had the necessary skills and knowledge to fulfil their roles.

On the first day of the inspection there was a registered manager in post at the service. 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. However, during the process of the inspection we were informed by the director of operations that the manager had resigned from their position and the service had appointed a new manager who was in the process of registering with the commission.

There were not enough suitably trained staff on all the units to ensure that people received safe care and support that was tailored to meet their individual needs. The service had failed to ensure that staff received

appropriate training and support to help them develop the knowledge and skills needed to provide care which met the needs of people. This meant that the care provided did not consistently ensure that people were calm and settled and able to live full lives.

Across the service there was a heavy reliance upon agency nurses and care workers. This meant that people did not consistently receive care from staff who knew them well or who they knew and trusted.

The service had a system for monitoring accidents and incidents. However, not all staff had an understanding of what constituted an incident and therefore the correct process to report it had not been followed.

The service had a recruitment process in place to ensure that staff were safe to work with people living at the service.

The provider had not consistently worked in accordance with the principles of the Mental Capacity Act (2005) to protect people's rights. Physical intervention was being used routinely by staff when providing personal care to some people living at the service. This intervention was not documented in people's care plans and was not being recorded or monitored to ascertain the frequency of its use or whether the level of intervention was appropriate and staff were not being supported in finding an alternative method to support the person.

The provider had not ensured that the overall service was caring as they had not taken action to ensure that people were safe or lived in an environment that promoted people's dignity. However, the individual staff who supported people were kind and caring and treated people with dignity and respect. Visiting times were flexible to enable people to have regular contact with their family and friends.

Care plans did not consistently reflect the needs of people. This meant that staff were not always aware of the risks associated with people's needs and lacked guidance on how to minimise potential risks. People did not always receive care and support that was suited to their individual needs and preferences. This meant that the care provided did not consistently support people to be calm and settled.

The provider had a complaints procedure, but historically verbal concerns raised by relatives had not always been addressed by the previous registered manager.

The management team did not have a clear oversight of the service and had failed to identify and respond to many of the issues raised during the inspection. There were systems in place to monitor the quality and safety of the service. However; they had not been used effectively and where shortfalls had been found appropriate action had not always been taken to resolve the issue.

Following the inspection the provider had devised an extensive action plan and was working towards improving the service and resolving the issues identified.

During this inspection we found several breaches of the Health and Social Care Act 2008. 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.

Not all staff had completed up to date safeguarding training.

Care plans did not always reflect people's current needs or portray an accurate picture of how staff were providing their care.

There was a heavy reliance on agency staff who did not always know people well.

Not all staff had an understanding of how to report or respond to accidents and incidents.

Is the service effective?

Inadequate

The service was not effective.

Staff had not completed training to provide them with the skills and knowledge to effectively fulfil their roles.

Staff did not have access to regular supervision sessions or annual appraisals.

The provider had not ensured that people's rights were fully protected under the Mental Capacity Act (2005).

Records relating to peoples' care and treatment were not fully completed to protect people from the risks of unsafe care.

Physical intervention was being used routinely by staff when providing personal care to some people living at the service. This intervention was not being recorded or monitored in line with the services policy.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not ensured that the overall service was caring as they had not taken action to ensure that people were safe or

lived in an environment which consistently promoted people's dignity.

Staff were kind and caring in their approach to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support that was suited to their individual needs and preferences. This meant that the care provided did not consistently support people to be calm and settled.

Activities were not used to distract people from distressed reactions.

People and relatives knew how to raise complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management team did not have sufficient governance and oversight of the service.

The systems the provider had in place to monitor the quality and safety of the service were ineffective in identifying all the shortfalls. Where shortfalls had been found appropriate action had not always been taken to resolve the issue.

The provider had implemented an external review of the service and was working in conjunction with the local authority on an extensive action plan to drive improvement forward.

Foxburrow Grange

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 took place on 10 and 30 March and 6 April 2017. On the first day of the inspection the team consisted of two inspectors, an expert by experience and a specialist professional advisor in nursing care for older people. On the second day of the inspection two inspectors were present and on the final day of the inspection one inspector looked at records relating to the maintenance and safety of the building and staff files.

During the inspection we focused on observing interactions between people living in the service and the staff who cared for them. We spoke with six people who lived at the service, eleven visiting relatives and visitors, five permanent nursing staff, two agency nursing staff, eight permanent care workers and three agency care workers. We also spent time with the care service manager, the newly appointed registered manager and the director of operations and toured the building looking at the environmental standards within the home. We looked at records relating to the use of medicines and assessed how medicine was managed, stored, administered and disposed of.

To understand how the provider responded and acted on issues related to the care and welfare of people we reviewed the care records and risk assessments for nine people who used the service. We also looked at four staff files to see whether staff had been recruited safely and looked at complaints and compliments received by the service. We also looked at records that related to how the home was managed such as staff rotas, staff training records, a range of audits and the results of quality assurance surveys. Reviewing these records helped us to understand how the provider monitored and managed the quality of the service.

To help us understand people's experiences of the service we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Before the inspection we liaised with the local authority quality improvement and organisational safeguarding teams. We also reviewed the information we held about the service including information from previous inspection reports and statutory notifications the provider sent to inform us of events which affected the service. A statutory notification is information about important events which the provider is required to send to us by law.

Requires Improvement

Is the service safe?

Our findings

Across the service there was a heavy reliance upon agency nurses and care workers who did not always know people well. This combined with care plans which did not always reflect people's needs and a lack of safeguarding training for permanent staff meant that the service had not consistently taken the appropriate measures to ensure that people living in the service were kept safe from harm.

Our discussions with staff showed evidence that they were aware of indicators of abuse and knew how to report any worries or concerns both within the service and, if necessary, to external organisations. However, records showed that not all staff had completed up to date safeguarding training. Therefore, we could not be confident that all the staff were aware of the process to follow if a concern arose.

There was a whistle blowing policy in place. All the staff we spoke to were aware of the policy and told us that they would be confident reporting any concerns about the safety of people or the behaviour of other staff members.

Records showed that risks associated with people's care needs were not always recorded and there were not always clear guidance for staff about how to manage risks or to mitigate the potential for reoccurrence. Care plans did not consistently reflect people's current needs or portray an accurate picture of how staff were providing their care. For example, one person's care plan advised that they required the assistance of two members of staff. However, when we spoke with staff they informed us that three staff members assisted the person because they became distressed and at times resisted staff assistance. This person's care plan contained no clear guidance for staff about how to manage this behaviour or support them when their anxiety levels increased. When we spoke with the provider about our concerns they committed to addressing the existing gaps and to ensure that risk assessments and care plans reflected people's needs in the future.

On the second day of the inspection the service had completed 'one page profiles' for people. The director of operations explained that these were being used to provide staff with an outline of important factors about people's care and how to best support them. However, when we reviewed these we found that they did not always provide staff with essential information about potential risks to themselves and to others. For example, we were aware of a safeguarding alert that had been raised by the service regarding a person living at the service. When we spoke with staff they were able to inform us of the measures that had been implemented to support the person to minimise the risk of reoccurrence and to protect others from harm. However, when we reviewed the person's one page profile it contained no information for staff about the incident or guidance for staff about potential trigger factors or how to manage behaviours. This meant that the person and other people remained at risk of harm. This risk was further increased by the service's reliance upon agency staff who we could not be assured would have access to the appropriate information about how to support this person safely. We discussed our findings with the management team who acknowledged that they were aware that not all of the one page profiles contained the correct information and they reassured is that they were in the process of reviewing them with staff.

We also found that staff did not always adhere to the advice recorded in people's care plans which meant that we could not be sure that people were consistently kept safe from harm. In addition, the information in the risk assessments did not always support staff to fully manage the identified risk. For example, people who had been identified as being at risk of developing pressure areas had been provided with pressure relieving equipment such as air flow mattresses. Staff told us that people's mattress settings were reviewed on a daily basis. However, records showed that this was not consistently happening across all the units. When we reviewed the mattress settings we also found that none of the mattresses were set at the recommended flow rate to ensure that people were getting their recommended pressure relief based on their weight. We also noted that three out of the ten people reviewed had not been weighed since December 2016. This meant that people were not being appropriately supported to reduce the chance of developing pressure sores.

We observed staff supporting people with manual handling to move from one place to another. Staff were calm and patient with people and gave them verbal prompts and encouragement throughout the procedure. We saw two staff members using a stand aid to assist a person, one staff member said, "We are going to have lunch now. [Person's name] can you hold that for me? We are going to stand up. Use strong muscles in your legs." However, although this was a very positive verbal interaction the person appeared unable to take weight through their legs which resulted in them hanging in the sling. This meant that the most appropriate piece of equipment to safely support the person was not being used by staff. A stand aid is a piece of equipment which is used to enable transfers from one seated position to another. In order to be assessed as being safe to use a stand aid a person should be able to take some weight through their lower limbs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we identified concerns about the staffing levels at the service. Some people living at the service had complex needs and our observations found that not all of the units were staffed appropriately to provide people with the support that they needed in a timely manner. For example, in the afternoon on the first day of the inspection we observed that on one of the units an agency staff member was providing one to one care to a person in the communal lounge area. They were alone in the area with four relatives and several other people. We saw one of the relatives inform them that another person required assistance because they were slipping out of their chair. The agency staff member did not know the person and therefore did not know what level of assistance they required and there were no other staff members available to assist or advise them. It took 20 minutes before another staff member was available to assist with repositioning the person. On another occasion we observed a person, who appeared to be in distress, sitting on their own at the end of the corridor. When we spoke to a member of staff about this they informed us that they were an agency staff member and were providing one to one care to another person so were unable to go and assist the person in distress. There were no other staff members available on the unit at this time. Approximately 10 minutes later another staff member came onto the unit, when we spoke with them they told us that they were also agency staff.

Some relatives and staff also raised concerns with us about the staffing levels. One member of staff said, "Tell me legally where do we stand? Do we care for people or fill in the legal paper work?" Each unit was managed by a team leader, who was a nurse. They were responsible for managing the unit as well as completing clinical responsibilities. However, they were only allocated 13 hours a week to complete their non-clinical responsibilities and one of the units had no permanent member of staff employed within this role. We discussed our concerns with the management team and when we returned to the service on the second day of the inspection the unit leader roles had been made into supernumerary posts. This meant

that staff had the time required to safely manage the units. The director of operations also informed us that they had successfully appointed into the vacant post.

Due to staff leaving, long term sick leave and a number of vacant posts the service was reliant on the use of agency staff to backfill vacant shifts. On the first day of the inspection we found that on two of the units there were a high number of agency staff working without the direct support of permanent staff. This raised concerns and our observations confirmed that people were not receiving individualised care from staff who knew them well. Some people living on these units had complex needs and we could not be assured the agency staff had been provided with the necessary information to enable them to effectively and safely meet their needs. One relative spoke to us about their concerns about the negative impact that this was having upon the care provided to their loved one. At the end of the first day of the inspection we discussed our concerns with the management team who confirmed that they would review how the service supported agency staff to ensure that care was delivered safely. On the final day of the inspection the manager showed us minutes which were taken during a group supervision session attended by agency staff. The session had been used by the manager to inform staff of the values and ethos of the service and to support them to become familiar with the needs of people that they were caring for.

Staff were aware of the procedure to follow in an emergency. On the first day of the inspection a person became unwell. Staff responded appropriately by completing observations, allocating one staff member to stay with the person whilst another went off to call the ambulance. Personal emergency evacuation plans (PEEPS) were in place in all records we reviewed in order to aid safe evacuation in the event of a fire. In addition, a coloured sticker system was in place to identify how people would be evacuated in a fire, however this system was not fully understood by all staff. Some staff knew the colours related to people's level of mobility but did not know that this was also related to the method of evacuation in the event of a fire.

The team leader took responsibility for monitoring the number of urinary tract infections, falls, and accidents and incidents on the unit on which they were based. The information was collated and given to the manager on a monthly basis to provide them with an overview of the incidence across the service as a whole. However, records showed that although the there was a system in place for recording and monitoring accidents and incidents, the appropriate action had not always been taken to address the issue. Not all of the staff that we spoke with were clear about what constituted an incident and we saw that on some occasions staff had used behavioural charts to document incidents. Records also showed that there had been occasions when, following an accident, staff had not and followed the correct procedures to ensure that people were kept safe from harm. This meant that we could not be assured that all incidents were being reported or responded to appropriately.

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. 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.

The provider had a recruitment policy in place to ensure that staff were recruited safely. 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. We looked at the recruitment files of four staff members. Each file contained a copy of the member of staff's job descriptions, references and proof of identity. 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.

The service had a policy in place for the management of medicines. This included the ordering, storing and return of any unwanted medicines to the pharmacy. We reviewed the stocktaking of medication and found that they were accurate. Temperatures of the room used to store medication and the medicine fridge were checked to make sure medicines were stored at the right temperature so were safe to use. The service supported people with their medicines and when medicines were administered a record was made in the person's medication administration record, (MAR). We checked the stock of medicines and saw that they matched people's records. The service had a protocol in place to guide staff when people needed to take medicines as required (PRN) and for the administration of homely remedies. Homely remedies is another name for a non-prescription medicine used in a care home for the short term management of minor, self-limiting conditions, such as toothache, cold symptoms and headaches.

Staff told us that they had received medicine training and had their competency assessed to ensure they had the skills and knowledge to support people safely with their medicines. Records confirmed that staff competencies had been reviewed and where errors had been identified action had been taken to resolve the problem. Monthly medication audits were completed by the deputy manager and in addition an external company completed regular audits.

Inadequate

Is the service effective?

Our findings

Although on the whole relatives provided positive feedback about the service, we found that the service was not effective. The service had failed to ensure that staff received appropriate training and support to help them develop the knowledge and skills to appropriately care for people and consent to care was not always sought in line with current legislation and guidance. This meant that the care provided did not consistently ensure that people were calm and settled and able to live full lives.

Staff did not have the knowledge and skills to ensure that an effective strategy was in place for managing people's behaviour. Our observations showed, and staff confirmed, that physical intervention was routinely used when providing personal care to some people living at the service. For example, on one occasion we observed four members of staff entering one person's room to assist them with personal care, however when we reviewed their care plan it stated that they required the assistance of two staff members. When we spoke with the staff that had gone in to assist the person, three of them said it was for reassurance. However, one of them who was a permanent member of staff told us, "[Person] scratches. So someone holds [person's] hands to stop [person] scratching and another holds the legs whilst the other two do the changing using equipment." Other staff members also told us of other people who required the assistance of more than two staff members to assist with personal care, when we reviewed their care plans all of them had been assessed as requiring the assistance of two staff members. This intervention was not documented in people's care plans and was not being recorded or monitored to ascertain how frequently it was being used or whether the level of intervention was appropriate. Consequently staff were not being supported to find an alternative method of to support the person. This was a breach of the services physical intervention policy.

When we discussed our concerns with the management team they had been unaware of the issues we raised. On the second day of the inspection we were informed that the service had sourced a new training provider and that a member of staff with specialist positive behavioural support had been seconded from within the organisation to support staff and review people's care plans. We reviewed the care plans for people living in the service with whom staff had previously used physical intervention when providing personal care. Each person had a behavioural support plan in place which clearly identified behavioural trigger factors and included guidelines and de-escalation techniques for staff to follow. Where interventions had been necessary, these had been discussed at team handovers. This provided staff with the opportunity to discuss with their colleagues what measures had been effective and for senior staff to monitor the interventions and ensure that they were appropriate and proportionate.

Some people who lived in the service were not 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

procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

Although when we spoke with the management team they understood their responsibilities under the MCA and around protecting people's rights the training matrix for the service showed that not all staff had completed training in this area. The meant that staff did not always understand their responsibilities to ensure people were given choices about how they wished to live their lives. Records showed us that consent to care was not always sought in line with current legislation and guidance. Although we saw evidence of best interest decision making in relation to some people's care this was not consistent and MCA's were not always in place and when they were, they were not decision specific. For example, we saw that some people had door sensors in place to alert staff when they were leaving their rooms or in some cases that someone was entering their room. However, there was no evidence that they had consented to this or that an MCA or best interest decision meeting had taken place to support the decision.

Whether or not people had appointed a lasting power of attorney (LPA) was not clearly documented in their care plan. An LPA is a legal document that allows someone to appoint one or more people to help them make decisions or to make decisions on their behalf in relation to their health and welfare or finance.

We also found that there was an inconsistent approach the application of DoLS. Some people had been assessed as lacking capacity but no application for a DoLS had been made and in other cases where an application had been made and the decision had been granted the date for the review of the DoLS had expired but no additional application had been made.

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the training matrix for the service and found that not all staff had completed the necessary training to provide them with the skills and knowledge to enable them to provide effective care to all the people living in the service. Some staff had not completed up to date training in manual handling, Mental Capacity Assessments, safeguarding or fire safety. We also saw that there were people living in the service with a diagnosis of Huntingdon's and diabetes; however there was no evidence that nursing staff had completed specialist training in these areas.

Staff told us that they felt well supported and had access to regular staff meetings and informal supervision from the management team. However, records showed that staff did not consistently have access to annual appraisals or regular formal supervision sessions to support them with their personal and professional development. We looked at four staff files and none of them contained an up to date appraisal. We found very little documentation to show support and development for staff, instead the focus had been on issues around poor performance. Records showed that for some staff the same performance issues had been discussed on several occasions and there was not always sufficient evidence to demonstrate the concerns were followed up and resolved in a timely manner. For example, following a medication error one staff member had been required to complete a medication competency review. The review had been started but not all of the sections had been completed. There was no indication as to whether they had passed or failed and there was no evidence of this being discussed with the staff member.

These failings are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives gave positive feedback about the food and the choices that people had at meal time. One relative told us, "Meals here are great. At Christmas dinner we had wine. The chef will make omelette if you don't like

the choice." Our observations however, showed that people's meal time experiences varied. We saw that some people ate where they chose and that staff sat and chatted with them whilst they ate their meal. We also some people were supported to be independent through the use of assistive cutlery and crockery. Some staff were able to explain to us about people's different dietary needs and ensured they got food that met their choice and preference. However, we also saw other staff members placing meals in front of people with no verbal interaction and adding sauce to people's plates without first asking the person if they would like it.

There were also inconsistencies across the units as to how effectively staff were monitoring people's food and fluid intake. We found that some records were completed correctly including the quantities of food we had witnessed people eating and that daily fluid targets were clear and calculated according to people's weights. However, we also found that there were gaps in the recording on some charts. This meant that we could not be certain that staff were consistently taking the appropriate action to protect people against the risk of dehydration. Some relatives also raised concerns to us about how their family member's fluid intake was being monitored by staff. One relative told us, "[Relatives] liquid and fluid records show some very large gaps and often don't reach the target values and no-one seems to be monitoring the charts." Another relative said, "I ask them to give her a hot drink like tea in the afternoon, evening. But you can see that the records show they have given her nothing but squash since lunch. I have brought the monitoring of fluids and recording, especially the gaps, which have been up to eight hours or more, up on several occasions, both verbally and in writing, but it doesn't seem to have any effect."

On three of the four units staff told us weights were completed at least once a month. However, we noted on each unit that some people who were predominantly cared for in bed had not had their weight checked since December 2016. The current nutritional risk assessment used by the service required monthly weights in order to determine the level of risk. This therefore, put people at risk of malnutrition going undetected.

These failings amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

In the main, people, their relatives, and staff spoke highly of the service and following the inspection several relatives provided positive written feedback. One relative told us, "[Person's] entire condition, health and mental attitude has improved beyond all recognition thanks to the excellent care [person] is receiving. We visit regularly and engage with other families while there. From the interaction I know that our view is shared by other families. We find the staff very approachable and have a very warm approach to providing the care needs my [relative] requires." Another said, "All the staff from the senior management through to the housekeeping staff are friendly, caring & helpful." However, other relatives expressed concern to us about the services reliance of agency staff and the impact that this had on the care that people received. Records showed, and our observations confirmed, that the provider had not ensured that the overall service was caring as they had not taken action to ensure that people were safe or lived in an environment which consistently promoted people's dignity.

Care plans contained a 'This is me' section, which provided details about their life story reflecting their likes and dislikes. We found that this had not always been completed and where it had been we did not see staff using the information to effectively engage with people living with dementia. For example, one person's care plan contained information about their love of animals and details about pets that had been of particular importance to them. Staff told us and we observed that the person became distressed at times believing that they needed to return home to feed their animals. There was a one page profile in place for this person but neither that nor the person's care plan contained solutions for staff about how to manage this behaviour or how to use their love of animals to engage with them and reduce this distress.

We did however; observe that the individual staff who supported people were kind and caring and treated people with dignity and respect. On the whole the atmosphere across the service was calm and we heard staff speaking to people in a pleasant and kind tone. One staff member told us, "We all want to do what is right. We are all passionate about giving people the best life we can." Throughout the inspection we saw that doors were closed during personal care and staff knocked and waited to be invited in before they entered people's room. We also observed staff respecting people's dignity by discreetly adjusting their clothing to cover their underwear when they stood up. However, we also saw that one person had been moved to a unit upstairs whilst building work was taking place on the unit they lived on. We were told that they had moved some weeks ago however, there was no name on the door of the person's room and when we asked staff who was in the room they could not tell us their name.

Advanced care planning was in place to support people at their end of life. Where appropriate preferred priorities of care (PPC) had been completed and these reflected peoples preferred last wishes and was updated if any changes were requested by people and their legal representatives. Staff that we spoke with were aware of how to contact and involve other members of the multidisciplinary team if they required additional advice or support and there were systems in place to ensure anticipatory medicines were sought where required when people were nearing the end of their life. Staff told us they involved relatives and that they were welcome to stay overnight so they could spend time with people in the last hours of their lives. Should syringe drivers be required the senior care staff told us the nurses would do it in liaison with

Macmillan nurses and the GP.

Requires Improvement

Is the service responsive?

Our findings

Records showed that people had been assessed before being admitted to the service. However, the assessments had not always provided an accurate reflection of the person's level of needs once they were admitted to the service. We also found new people admitted to the service were not always placed on units which were appropriate to meet their needs. Consequently, there had been occasions where the person and other people living in the service had been placed at risk of harm.

People's care plans did not always contain information for staff about how to manage potential behavioural trigger factors. For example, during the inspection we heard one person becoming increasingly distressed and stating that they wanted to go home. One staff member told us that the person often displayed this particular behaviour and that it appeared to coincide with their relative leaving. The person was receiving one to one support however, the staff member providing this did not appear to know how to calm the situation or how to use distraction techniques to reduce the person's distress. We reviewed the pre-admission assessment that had been completed for the person and saw that it had raised concerns that they were at a high risk of absconding and of verbal aggression. The assessment had not been dated and did not identify who had completed it. We reviewed the person's care plan and saw that staff had completed behavioural charts which recorded incidents of verbal aggression from the person but there was no clear plan for staff to follow to support the person to transition from when their relative left. We discussed our concerns with the manager and the director of operations who informed us that they were in the process of addressing this issue and were reviewing the pre-assessment process.

We observed occasions when staff did not respond appropriately to people with dementia who were displaying signs of verbal distress. On two occasions, instead of backing away from the situation or reassuring the person, the staff members either retaliated verbally or argued with the person. In both instances staff involved were agency and seemed unaware that their response was aggravating rather than resolving the situation. On one occasion the situation was eventually resolved when a permanent staff member came and took the other person away to a different part of the lounge.

The feedback that we received from relatives regarding their involvement in reviewing people's care plans was inconsistent and there was little evidence to show that people and their relatives had been involved in reviewing their care. Some relatives told us that they felt that they were kept well informed of people's progress and had contributed to the review of their loved ones care plan. One relative told us, "If [they] are unwell they tell us what's happened." However, another relative told us that they were not confident that important information was always passed on between staff and this made them worry about the standard of care that their loved one received. They went onto say that their relative had been assessed by a speech and language therapist who had advised that they were placed onto a soft diet, however when they looked at their food chart it was recorded that they had been given toast.

During the inspection we observed both care staff and volunteers sitting and talking to people. Organised activities, including flower arranging, bingo, karaoke and animal therapy, took place in a communal area and were accessible for people from different units to attend. Staff and relatives also told us that children

from the local school also regularly came to the service to interact with people. However, we found that that this meant that there was a lack of meaningful and structured activities on offer to people, such as those who were cared for in bed or people whose behaviour caused them to become anxious or distressed. who were unable to leave their unit.

There was a system in place for handling and responding to complaints. We looked at the complaints file and saw that written complaints had been responded to in writing by the previous manager. However, some relatives reported that they had verbally raised concerns with the previous registered manager but the issues raised had not been addressed and this had resulted in them losing confidence in the process.

Requires Improvement

Is the service well-led?

Our findings

Both relatives and staff were complimentary about the organisation and told us that the chief executive was a visible presence at the service. During the inspection process the registered manager resigned from their position and a new manager was appointed and was in the process of registering with the commission. The service had clearly been through an unsettled period but staff were positive and had confidence in the new management structure. One staff member told us, "We're working hard and we're on the right track to improving and embedding good practice." Another said, "I think that the changes that have been made are really positive."

Whilst there were systems and processes in place to assess, monitor and manage the service the provider had failed to maintain a clear oversight of the service. For example, physical intervention techniques were being routinely used by staff when providing personal care to some people. When we brought this to the attention of the management team they were unaware of the extent to which it was being used at the service.

Audits had been completed regularly but they had not captured all of the issues that were identified during the inspection. For example, we found that records relating to the care and treatment of people were not always complete or accurate however, internal audits had failed to reflect this. Where concerns had been raised it was not always clear to see what action had been taken to resolve the issue. This meant that the provider had not taken adequate steps to monitor and improve standards and ensure that people living in the service were kept safe and receiving care which met their needs.

The service had failed to ensure that staff received appropriate training to provide them with the knowledge and skills they needed to provide care which met the needs of people. For example, several people living in the service had a diagnosis of dementia. However, we saw that not all the staff had the knowledge and skills to support people appropriately or knew how to reassure and calm people if they became distressed. This meant that the care provided did not consistently ensure that people were calm and settled and able to live full lives. Staff had not received annual appraisals and did not have access to regular supervision to support them in their professional development. Completion of staff appraisals and supervision sessions would have enabled the management team to identify some of these shortfalls in staff training and understanding.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had instigated a number of measures to address the concerns identified during the inspection including; a review of staff training; a change in the management structure which included making the unit leader posts supernumerary and the employment of a Clinical Nurse Specialist in dementia care. They had also commissioned an external review of the service to ascertain how the problems had escalated to the point that they had. This demonstrated that they were committed to working towards making the necessary improvements and to avoid the making the same mistakes in the future.

The organisation prided itself on its open and transparent culture. During the inspection the management team had held staff and relative meetings to discuss the issues raised during the inspection and to support staff and relatives in moving forward.

The manager held daily head of department meetings. This gave them the opportunity to discuss what was happening in the home on that day, including activities, healthcare appointments and to highlight any staffing issues. In addition to this the team leader on each unit submitted monthly reports to the registered manager which provided details including; the number of falls that had occurred, any infections, such as urinary tract infections and what medication the person had been prescribed, medication errors, accidents and incidents and any safeguarding concerns that had been raised.

The manager understood their responsibilities to the Care Quality Commission (CQC). They reported significant events such as safety incidents, in accordance with the requirement of their regulation.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Risks associated with people's care needs were not always recorded and there were not always clear guidance for staff about how to manage risks or to mitigate the potential for reoccurrence.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Staff did not always understand their responsibilities to ensure people were given choices about how they wished to live their lives. Consent to care was not always sought in line with current legislation and guidance. MCA's were not always in place and when they were, they were not decision specific.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People's food and fluid intake was not always being accurately monitored. This meant that we could not be certain that staff were consistently taking the appropriate action to protect people against the risk of dehydration.

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

Treatment of disease, disorder or injury	Whilst there were systems and processes in place to assess, monitor and manage the service they were ineffective and the provider had failed to maintain a clear oversight of the service. Staff had not received annual appraisals and did not have access to regular supervision to support them in their professional development,

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not completed the necessary training to provide them with the skills and knowledge to enable them to provide effective care to all the people living in the service.