Hallmark Care Homes (Billericay) Limited

Anisha Grange

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

The inspection took place on 11 and 12 May 2016 and was unannounced.

Anisha Grange is a nursing home that is registered to provide accommodation, nursing and personal care for up to 74 older people, some who may have needs associated with dementia. Care was provided in three units over three floors. Valentine, the nursing unit, was on the ground floor, people with dementia mainly lived in the Primrose unit on the first floor, whilst people who did not have nursing or dementia needs predominantly lived in the Autumn Way unit on the second floor. At the time of our visit there were 74 people living in the service.

A registered manager was 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.

We found a number of 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.

Action plans were already in place to positively address many of the areas of concerns which we had picked up during our inspection. However, this had not yet resulted in improvements in the quality and safety of the service people received.
People were not always safe. There were not enough staff to meet people's needs and minimise risk. Medication was managed and stored safely. However, medicines on the Valentine unit were administered by the member of staff who was also responsible for running the unit, which increased the risks of errors due to frequent interruptions and resulted in delays in people receiving their medicines. Staff were safely recruited and protected people from the risk of abuse.

There was an extensive menu on offer throughout the day and kitchen staff met with people to consult with them about the choices available. However, people did not always have a positive mealtime experience. There were not effective systems in place to ensure people who could not communicate verbally or who needed more support had ready access to drinks and snacks outside mealtimes. Measures to monitor people who were at risk of dehydration and malnutrition were not effective.
Staff did not always feel listened to and supported. Whist staff received a wide range of training; there were limited systems in place for the manager to monitor the levels of skill and knowledge amongst the staff team.
Whilst some staff were caring, other staff were often focused on tasks rather than the person they were supporting and did not always speak to people kindly.
Care plans and risk assessments were in place to provide guidance for staff about how best to meet people's needs and preferences. People were supported to access relevant health and social care professionals. Staff

arranged a wide variety of activities and events designed to enhance people' quality of life. Lack of staffing meant support was not always person centred and some people were not able to attend the activities on offer.
The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. Whilst some staff asked for consent before carrying out care this was not consistent across the service. Improved training had been set up to increase knowledge and understanding of the MCA.

The manager was approachable and committed, however they did not always communicate with care staff and resolve their concerns effectively. There was insufficient supervision and a lack of oversight of the clinical care people received. People knew who to complain to and the manager responded to people's concerns in a timely manner.

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 enough staff to meet people's needs and preferences

Risks to people's safety were not always managed effectively

Staff were safely recruited. They knew what to do to protect people from abuse

Is the service effective?

Requires Improvement

The service was not always effective

People did not have a consistently positive experience of mealtimes. Drinks and snacks were not equally accessible to everyone outside of meals.

Staff were not supported consistently and there were limited systems in place to measure staff skills and knowledge.

People were enabled to make their own choices where they had capacity, although not all staff sought people's consent before providing care. Decisions made on people's behalf were done in their best interest.

People had access to other health and social care professionals when required

Is the service caring?

Requires Improvement

The service was not always caring.

People could not be assured staff would treat them with kindness.

When staff were supporting people they did not always involve them fully or treat them as individuals.

People's privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were enthusiastic about developing meaningful and varied activities and events, however lack of staffing meant people did not always receive person-centred care.

People's care was assessed support plans were in place which outlined their individual needs and preferences.

People knew who to speak to if they wanted to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager was approachable however communication with care staff and the supervision of clinical care was not effectively managed within the service.

There was a low morale amongst the care staff and measures to address this had not yet resulted in improvements.

There were systems in place to check the quality of the service but where action plans were put in place as a result, these were not effectively carried out.

Anisha 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.

The inspection took place on 11 and 12 May 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist nursing advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The nursing advisor was used to check that people's health and care needs were met in a safe and effective way

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 the information included in the PIR along with other information we held about the service. This included safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able verbally to talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service. As part of our observations 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 with us.

We met with the registered manager, the clinical lead, the provider, the regional manager and the provider's head of care. We also met with the head of hospitality and the chef, 12 members of care staff, 18 people who used the service and eight family members. We also spoke with two health and social care professional to find out their views on the service.

We reviewed a range of documents and records including the care records for people who used the service to see if the records were accurate and reflected their needs. We also looked at ten staff files and documents relating to the employment of staff, complaints, accidents and incidents and the management of the service.

Requires Improvement

Is the service safe?

Our findings

Whilst people told us they felt safe at the service, a high proportion of the people expressed their concerns about staffing levels and gave us examples where their needs were not being met in a timely way. For example, one person told us, "I call and they can't take me to the toilet." Family members we spoke to were also unhappy with the number of staff available. A family member told us, "They've not always got enough staff."

During our visit, our observations supported the feedback we had received that there was insufficient staffing to meet people's needs. Whilst we were particularly concerned about the deployment of staffing in the Valentine unit, we felt staffing was an issue throughout the service. We looked at records to see whether staffing levels were particularly poor on the day of the inspection. For example, we looked at rotas which confirmed that over the past week there had been times when the Autumn Way unit was being staffed at night by two members of staff. A person explained that this meant staff could not always respond to their request for help, "Two people have early showers, so if I need help then, nobody's available."

In a recent survey people were positive about the service and had responded overwhelmingly that the service was a safe and secure place to live. However, in the area of 'staff and care' people were least likely to strongly agree when answering the questions 'Staff are available when needed' and 'Staff have time to talk to me.' The manager confirmed that following recent discussions with senior carers, they had responded proactively and an additional member of staff was due to be allocated consistently to Autumn Way unit at night time. However, we received feedback from staff and people that when another unit was short-staffed there were constant demands on staff to work across units. One person described the impact of this, "They should have three staff on at night, but often one is sent down to another floor. I feel sorry for the night staff – they're rushed off their feet."

Managers were able to electronically measure call bell responses to see how quickly staff responded to calls for assistance. During our visit we observed three occasions when call bells rang for over five minutes. On one occasion we sat with a person for nine minutes before a member of staff came in. People told us whilst staff did sometimes respond to call bells quickly, they would then turn the bell off and they would have to wait whilst staff supported a person in greater need. This impacted on the quality of support people received. One person told us, "Staff are always being called away when they're with me. I think they should finish with one person first, rather than always rushing off in the middle of things." A relative told us about the impact of staffing levels on one person. They told us, "[Person] asks to go to the toilet, staff often leave them, or they say, 'I'm busy right now, I'll be back.' They often don't come back." We spoke directly to the person who confirmed they were frequently told to wait as staff were rushing to respond to a call. A health and social care professional told us numbers of staff in the Valentine unit were low in the evenings and that they felt these staffing levels were not adequate, given the level of need in the unit.

The service used an Electronic Medication Administration Records (EMAR) system to enable the manager and clinical lead to monitor the administration of medicines. Staff understood the system and told us it worked well. We were told the system limited the number of missed medications. We saw an example of

where there had been a medication error and the manager had addressed this with the staff and put in measures in place to monitor that member of staff when they administered medicines again. Medicines were stored in a locked trolley and storage room and the member of staff was able to clearly explain the medication signing in and out procedure. There were risk assessments in place for people who self-medicated and checks were carried out to ensure they could still manage to administer their medication safely.

On the day of our visit we observed the morning medicine round on the Valentine Unit finished at 12.15pm. This meant some people received their morning medicines up to three hours late. The manager told us that the round usually lasted around two hours. We looked at the records for the week leading up to our visit and noted that the delays we had observed were not a one-off occurrence. For instance, a person's medicines were delayed on the 9, 10 and 11 May by between two and three hours. The reason given on the system for the delays was 'given late due to intervention with other persons'. We noted that the nurse administering medicines was knowledgeable and mindful of the delays. They adjusted the timings of the medicines due later in the day to minimise any potential risks to people's health. They had also ensured they prioritised the timings of the administration of any time-sensitive medicines.

The delays in administration of staff resulted from poor deployment of staff. In the month prior to our visit ago the senior carer role had been removed from the Valentine unit. This meant that the nurse on duty became the senior member of staff. As well as directing care staff, the nurse was required to answer calls, for example from external health professionals. In addition, the physical health needs of many of the people on the unit were complex and could only be carried out by a qualified nurse, for example supporting a person with their syringe driver. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin.

The level of expectations on the nurse in the Valentine unit were unrealistic. We observed that the other members of staff were left with little or no supervision and on several occasions there was confusion about what needed doing on the unit. In addition to delays in medicine administration, the system in place aggravated the potential for medicine errors due to disruptions to the nurse responsible for this task

Whilst our concerns centred on the risks to people's health and safety from insufficient staffing the overall quality of people's lives was also affected. One of the senior staff said they preferred to send staff from their unit to accompany people who went to the social activities elsewhere in the service, for example to a craft session, as this would enable people to be supported by staff who knew their needs well. Throughout the day we observed people walking around the service, benefitting from the varied resources on offer. Those who were less mobile told us lack of staff meant they often had to wait if they wanted to move around the service and as a result they did not have these same choices available to them. Our observations confirmed this. For example, we noticed that at lunch time many of the people on the top floor ate in their rooms. We spoke to a person who needed support to move to the dining room and they told us, "Oh, they're busy, so they've asked me if I'll have my dinner in here today. It's not very easy, but it's only for one day." The person told us they did not mind eating in their room as this did not normally happen, but we noted staffing levels had limited the choices available to them.

We discussed our concerns regarding staffing with the registered manager and the regional manager. The regional manager told us, "Our staffing is high by industry norm." The provider and registered manager also described how an independent assessment of dependency of each service user was carried out and this information was then used to allocate staff according to the dependency levels and we were shown an example of the application of the tool to determine staff numbers.

We discussed the delays and risks to the administration of medicines in the Valentine Unit and we were advised by the manager that a senior carer would be re-instated into the unit, to mitigate the risk of disruptions during the administration of medicines. We were told however, that this was at the expense of one of the front-line care workers, so the numbers of staff on that unit would remain the same. Whilst the manager had dealt with the serious risk issues we had highlighted, they had not addressed the wider issue of the staffing levels within the service and the impact this had on people's overall quality of care.

The registered manager had failed to ensure there were sufficient numbers of staff to meet people's needs and keep them safe. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk was not always well managed. Staff were required to complete charts to monitor risks to people's safety and health, however this system was not working effectively. Records included whether people who were cared for in bed had been re-positioned, skin integrity and if personal care had been delivered. There was confusion about how many people were being monitored in this way. For example, staff gave us different accounts and were not able to provide a consistent rationale for why people were on charts. Staff said communication about the charts put in place for people was poor. They did not always know if a chart had been started or stopped and lack of involvement in discussions about people's health needs meant they did not understand why a person was being monitored or not.

We looked at eight sets of charts in the Valentine Unit. The charts had options showing whether the person required one, two or four hourly checks. None of the eight charts we looked at had this section completed so staff did not know what the expected checking duration was for each person. According to the charts, the maximum time allocated between checks was four hours. On all the charts we found evidence that checks, or the recording of checks, frequently exceeded this four hour period with one person's chart recording 8.5 hours between checks. Staff explained that some people only required re-positioning at night, hence the longer gaps during the day, this however was not written on any charts or in their care records. The lack of pressure sores indicated care was being provided appropriately. However, we were concerned that the organisations own policy for the management of risk was not being followed. We were not assured that the manager or clinical lead were able to monitor peoples' safety to ensure they were receiving the required care.

Staff completed risk assessments for people, as required. We felt that some of these assessments contained valuable advice for staff. For example, where a person was at risk of pressure sores, there was a photo, taken with their consent, showing what staff needed to look for when monitoring their skin. Each person also had a plan, should they need to be evacuated in an emergency.

The provider had a safe system in place for the recruitment and selection of staff. Staff were recruited with the right skills and experience to work at the service. Staff told us that they had only started working at the service once all the relevant checks had been completed. We looked at recruitment files for ten staff and saw that references and criminal records checks had been undertaken and the organisation's recruitment processes had been followed. Where nursing staff were provided the correct checks were carried out to ensure they had the appropriate relevant qualifications.

Despite the dissatisfaction with staffing levels, most people told us they felt safe at the service. A relative told us, "[Person] has been here quite a while, and have had no falls or altercations with other people, so I think they are safe here." Staff had the skills and knowledge to protect people from the risk of abuse. Staff were able to describe different forms of abuse and knew what to do if they felt a person was not safe. Where people were assessed as being vulnerable to abuse there was guidance in place to advise staff. Staff

explained how they might recognise possible abuse where people were not able to communicate verbally. We saw from our records and previous discussions with the registered manager that they worked openly with social care professionals where there were investigations into people's safety.

The service was pro-active about achieving a high standard of cleanliness. For example, we saw that one unit had been assessed during an audit as not being adequately clean, which had been dealt with effectively and swiftly. We observed that the service was clean and odour free during our visit and people told us that cleanliness and hygiene levels were taken very seriously. We received positive comments relating to a recent outbreak of sickness and diarrhoea at the service, during which families were not able to visit whilst a deep clean was carried out. A person told us, "We all went down with the norovirus, and the home was closed for a while. The staff went down with it too, and they couldn't bring in relief staff for fear of spreading it. They coped very well under the circumstances, and staff worked hard, despite feeling unwell themselves."

Requires Improvement

Is the service effective?

Our findings

People who were verbal and more independent were able to ask for or help themselves to drinks and snacks throughout the day. For example, we noticed big bowls of fruit available throughout the service, however during our two day visit we did not observe anyone being offered or eating any fruit. One person told us, "I stay in my room, but I know there's a fruit bowl in the lounge. I ask them to bring some in, which they do." In one lounge, the bowl was placed on a table by the doorway. We asked people if the fruit was ever passed around. One person said, "Oh is there some fruit? We can't see it over here, why don't they put it in the room, rather than by the doorway?"

The manager told us that people could ask for snacks and drinks at any point and gave us examples of where this happened. We were also told that everyone had a bottle of water in their rooms which was refilled when empty. We felt that people who could not communicate verbally or who needed support to eat did not have equal access to snacks and drinks between meals. The hospitality manager explained that the service did not have a traditional 'tea-round' as they felt this was too institutional. They also told us people were able to ask for drinks and after activities there would often be a cup of tea. We asked the manager and the area manager how they could assure themselves the most vulnerable, non-verbal people had equal access to drinks, particularly where people had dementia and were mobile around the service. We were told that this had been discussed at management level and there were plans to provide drinks in a more formal structured way.

People were weighed and where they were at risk of malnutrition they had been referred to a dietician. A member of staff told us that one person was under the dietician as they were losing weight and that they supported them to have fortified food and their favourite fruit juice. Where people were at risk, staff were required to complete food and fluid charts to record what people had consumed during the day. There was some discrepancy in relation to how people's fluid intake was being monitored. We discussed our findings with the provider and were told the correct forms were kept centrally and the forms in people's rooms would be amended to prevent confusion in the future. We saw four records where fluid input was less than the target intake for each person being monitored. There was no written guidance of the action to be taken in this event, either on these monitoring forms or in the care plans. A visiting relative told us, "I think they're a bit lax on [relative's] drinking – we know they should drink more, as they are prone to infections."

We observed meals in three different dining rooms and saw that the rooms were beautifully laid out, for example with decoratively arranged serviettes, and choices of sauces and condiments on each table. Some people were positive about the dining experience, and we were told the people gave positive feedback at surveys and meetings about the meals on offer. One person said, "They do a very good quiche here which I look forward to. I'm quite satisfied with the food." Another person told us, "The last month has been a bit better for some reason, hopefully it will continue." We observed one person being assisted throughout their meal in a caring, patient manner and we another person who was being cared for in their room was coaxed kindly to encourage them to eat.

However, we did not feel people had a consistently positive meal time experience. One person told us,

"There's nothing wrong with the food, it's what they do to it. They get things mixed up. I order mash, I get chips. I say I don't like cream, they add it to everything in sauces." Where people had specific needs staff did not always give them the necessary support. One person sat asleep over their food and we noted very little attempt to encourage them to eat. We looked at their care plan which gave staff guidance about the support they required at mealtimes, which we had not observed being followed. Staff did not always use different methods of communication to support people's understanding of the options available, for example pictures of the different food choices on offer were not used for people who did not communicate verbally. Although there was a picture menu on every table staff were not observed to use this to enable people to make an informed choice.

We met with the staff responsible to preparing the meals and found they were enthusiastic about their roles and were knowledgeable about who needed assistance with eating or had specific dietary needs and allergies. For instance, we were told one person with diabetes loved a particular type of biscuit. We saw a recording log which highlighted which people across the service were at risk of choking, which had involvement from speech and language therapy and what specific dietary needs they had.

Kitchen staff held regular meetings with care staff regarding people's needs and preferences and any risks. For example, people who were on a specialist diet due to weight loss were assessed as 'red' to highlight the need to monitor their intake. Care had been taken to ensure people who needed soft or blended food could still have a pleasant meal time experience. For example, we had seen mousse being served at the meal that day and the chef told us this had been chosen as it meant people who needed soft foods could eat the same food as other people in their unit. We found this demonstrated a respect for people's dignity and during our observations of meals we saw a member of staff saying to a person, "Would you like a mousse or a cheesecake. I know you'd prefer something a bit soft so shall we try the mousse."

People's views had been listened to when making decisions about food and meal choices at the service. For example, the main meal was moved from the evening to lunch time following a survey of people at the service. There were meetings with people and their families to discuss food and their views. We were told people particularly liked the fortnightly barbecues which took place during summer. Staff knew people's preferences, for example one member of staff assured a person the mousse was lemon, and not butterscotch which they didn't like.

People told us that they felt staff were well-trained, and they had confidence in their knowledge, and their abilities to care for them well. One lady told me, "They're all trained well, but you can't teach people to really care – that comes from inside, doesn't it." We spoke to a member of staff who was very knowledgeable about medicines and all aspects of physical health care. Other staff were knowledgeable about dementia, however, during our visit we observed instances where staff did not have the necessary skills to communicate effectively with people with dementia. For example we observed a member of staff verbally offering choice to a person and when they did not hear or understand, the staff member kept repeating the same sentence, each time a little bit louder.

Staff gave us mixed feedback regarding the training they received. Where training was face-to-face staff felt they had been supported to develop their skills but many of the other courses were computer based which staff told us they did not find as effective. One member of staff told us, "The e-learning is hard as there's so much information to take in." Staff told us they received an induction when they started the job and we saw a comprehensive induction booklet in personnel files. There was an online system to record what training staff had been on which flagged up when training was due.

Whilst staff who were responsible for carrying out medicine administration had their competency assessed

there were very few other examples where managers and senior member of staff had observed people's competencies. It was not clear how the manager was assuring themselves that staff had the skills to provide the necessary support. For example, where there were concerns regarding a person's practice there was not always a comprehensive action plan in place to improve their skills.

We discussed our findings regarding the current training and observation of competency with the manager and the provider's head of care and they told us they were in the process of reducing e-learning and planning more practical training. We were told the service had appointed a senior carer as a Dementia Lead a month prior to our inspection and additional training was being provided in this area, however our observations indicated that these changes had not yet enabled staff to develop their skills throughout the service. We were told by the manager that they were also planning to increase observations of staff competency, and they showed us some excellent examples of the new measures being rolled out. However, at the time of our visit these improvements had not been fully introduced and we were not able to measure their effectiveness.

The feedback we received from staff was that they were not consistently well supported. For example, two members of staff said they did not know when they had last had supervision and had not attended any staff meetings. When we looked at the records, we saw that whilst supervision in some units was in line with the providers own policy, this was not consistent across the service. More experienced staff explained there were not sufficient staff available to support new staff adequately. Other staff were more positive, for example two members of staff said they had received regular supervision. New staff said although they were extremely busy and at times felt stressed, they did feel supported by their more experienced colleagues.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). We noted the manager had applied to the relevant authority for DoLS authorisation where people lacked capacity and needed constant supervision to keep them safe. The applications related to a number of different issues indicating that they were personalised according to people's needs.

Staff had received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance but discussions with them highlighted a lack of knowledge about the legislation. We observed staff offering choice to the people at the service, for example about what to wear each day. In addition, we observed that whilst some staff sought peoples' consent before providing care, we observed instances where this did not happen. For example, we observed a member of staff move a person in a wheelchair from one room to the next without asking their consent or discussing what they were doing. Managers were aware of gaps in knowledge in the area of MCA and had arranged for staff to attend more practical training to develop their skills further.

Where people had specific health needs there were details in their care plans on how best to support them. People were supported to access healthcare professionals and specialists according to their specific needs. We saw good evidence in the care records of involvement by external health care professionals such at GPs and chiropodists, for example. We observed ongoing input and visits from outside professionals throughout the time we spent at the service. The information was shared about the different health visits and appointments taking place at a daily meeting, attended by the heads of each department.

Requires Improvement

Is the service caring?

Our findings

We had some positive feedback from people who told us some staff treated them in a caring manner. A person described the staff team, "They're very good, they have a good laugh with me, which is very important." We observed people being supported and spoken to in a kind manner. For instance, a member of staff was seen comforting a person who was anxious. The member of staff was very patient and caring, drawing from their own experiences of anxiety in order to help the person involved. Another person told us staff understood their needs well, and would notice if they were having 'a bad day'. They told us, "A week ago I was feeling depressed and worried. Staff noticed I wasn't myself, and kept coming in to check on me, and made time to listen to my fears. I very much appreciated that." Some staff spoke about people with affection, for example, one member of staff told us, "[Person] is loved here, they take part in a lot of things and enjoy life."

However, whilst there were some good examples of compassionate and caring staff, we felt that due to the impact of low staffing and low staff morale people could not be assured they would be treated with kindness and respect. In particular, we observed pockets of the service where people were cared for by an unhappy staff team. We frequently heard staff complaining loudly about the conditions they were working in. One person said to us, "This member of staff often sits in the lounge watching TV and doesn't talk to the other people sitting there, it's as though they don't really care." Another person told us, "They're not always very polite to me, they say, 'you'll have to wait, we're using the hoist.' They're not very apologetic." We observed that some staff were focussed on the tasks being carried out rather than the person they were supporting. One member of staff told us there was not sufficient time to take into account people's personal preferences or individual needs.

Staff turnover meant there was a lack of continuity in the staffing team which impacted on people and their experience of care. One person said, "I often see strange people walking about who I don't know. It doesn't take much to introduce yourself, does it." Another person confirmed this, saying, "New staff should be introduced to everybody – we don't know who they are." Some people did not feel staff always knew them well or were aware of them as individuals. For example, one person told us, "They're mainly polite and kind girls, but I have different ones every day. They know the job, but not my routine. You get used to somebody, and then they go to another floor, or they leave."

Despite this focus by some staff on tasks, , we found that where possible people had been encouraged to express their views and be involved in developing their care plans. When this was not possible a family member had been consulted about the care their relative needed. We saw some examples where care plans and guidance to staff were worded in a specific way, following consultation with people.

We observed staff who were kind and respectful to the people they were supporting. However, people were not consistently treated with dignity and respect as staff did not always consider the impact of poor care. For example, one family member told us they felt their relative often needed attending to when they came to visit, 'I have to ask them to change [relative] – they always agree to do it, but they're never apologetic that I've found [relative] like that.' We saw a person had an untouched cold breakfast left on their bed tray at

10.30am. A staff member came in, offered to cut the food up and left the room. However we noted staff had not stopped for a chat and there had been no apology or recognition that the person would have to eat a cold meal. The person was not treated with dignity and respect in this interaction with the member of staff.

Confidentiality was maintained at the service, for example people's records were kept in a locked room. We noted that where a person had told something to staff which they wanted to maintain private from other people at the service, staff were respectful about maintaining their confidence. We often noticed staff knocking on peoples' doors before entering out of respect for their dignity, for example a person told as that domestic staff always knocked before returning clean laundry.

Requires Improvement

Is the service responsive?

Our findings

People told us that where possible, staff provided care that was tailored to their preferences. A person told us, "They understand my limitations. They know how I like things done. I like to have a wash with a sponge… and they leave me to do what I can do for myself." Whilst we recognised there was a positive focus on promoting varied activities and experiences we had concerns there were not enough staff to support people to make full use of all that was on offer and to offer person centred care. The opportunities on offer were not always available to the people in the service who required the greatest support and input from staff.

A member of staff told us that whilst they were passionate about the work, they could not always meet peoples' needs at a time which suited the person as personal care delivery took priority. Other staff said they had limited opportunities to spend meaningful time with people, for example chatting or sitting with people. This was confirmed by the some of the people we spoke to. We observed a member of staff enter a dining room to invite everyone some people to a birthday party. The people who were self-caring and mobile headed off to the party. The member of staff on duty explained that some other people the remainder of the people could not go as they had not yet been supported to go to the toilet due to insufficient staffing. We felt this demonstrated that lack of staffing affected in particular the most dependent people in the service.

People's care needs had been assessed by senior members of staff before moving into the service. Care and support plans outlined the support each person needed and where a professional had been involved, such as a dietician, action plans were clearly documented in the care plan. We found the care plans to be comprehensive and reviewed monthly or as needed. The quality of care plans was improving, for example we saw a member of staff had been asked to re-write a care plan to make it more person centred. Some people had a booklet called, 'All about me' to capture information about their life and preferences. One member of staff told us, "We encourage family members to add to the booklet. It's a growing relationship so we add to it as we get to know them."

There was a team of activity coordinators who were responsible for developing activities and events who were enthusiastic about their roles. They were putting together memory boxes specific for people with dementia to help staff to understand a person's life history and preferences. Although this initiative had not yet been rolled out fully in the service, we felt it would help address some of the concerns we had about the lack of person centred support provided to some of the people with more complex needs.

People told us there were plenty of activities on offer and they could pick and those they wanted to attend, subject to access to support from staff. We were told about regular outings. For example one person told us, "We've been to Chelmsford Museum, to Lake Meadows, to the shops. They've got their own transport, so they'll take whoever wants to go. Some also go to the local church at the weekend." Other activities included 'Pets as Therapy' dogs who visited the service to spend time with people, music and craft activities. The service had a hairdressing salon and therapy room which we observed people using throughout the day. We spoke to a social care professional who said they had seen a small group of people reading outside with a member of staff who they had observed as being very gentle and responsive to people's needs. There were also approximately 14 volunteers who participated in activities in line with their hobbies and interests.

Some people told us they were lonely and missed one-to-one contact, for example to play a board game. In particular, we found that in the Autumn Way unit, where some people were more able, there was some frustration that some of the activities were not at the level they wanted. For example, one person told us, "I go to choir which I enjoy, but nothing else challenges me. If I go to flower arranging I don't want to just put flowers in a vase. If I go to scrabble, I want to play someone on my level." Other people on this unit had similar views and there was scope to develop activities for people who wanted a challenge and to be further stimulated.

The service had introduced a 'Lucky Star Christmas Wishes' competition where the winners would have their wishes granted. We read in the newsletter about some examples where people had been supported to fulfil personal dreams, such as meet a friend they hadn't seen for years. We felt these were positive and meaningful events in the lives of the selected people. Staff also helped people celebrate special occasions and on the day of our visit we saw they had prepared homemade cake for an afternoon tea for a person's birthday.

There was a monthly newsletter which let people know about the extensive activities and special occasions which were on offer. For example, we saw a report on a recent 'Fine Dining with a Theme' event to celebrate Chinese New Year, which had been facilitated by staff and volunteers. Each newsletter had an article which focused on one person in the service and provided a detailed description of their personal history. We found the newsletter to be informative and entertaining and a positive publication.

The provider had a policy in place for responding to concerns and complaints. Most of the people and family members we spoke with told us that they felt comfortable raising concerns and giving feedback, for example a person told us they had spoken to the manager about the meals on offer. Families told us the manger was proactive about dealing with specific issues about the service provided to their relative. A family told us, "If we have any questions or concerns, we go to the senior staff. They never rush us, they'll come in and talk to us with [relative], or they'll talk to us separately." Complaints were logged and responded to individually and in a timely manner. A social care professional said that when they and a person's family had raised with the manager issues about the lack of consistency of staffing their feedback was taken on board and resolved. We were also shown minutes of meetings with residents of each unit where managers had gathered feedback from people at the service. The minutes showed predominantly positive comments, for examples people had been positive about the care received "with all care assistants coming in for praise."

Requires Improvement

Is the service well-led?

Our findings

During our visit we found a lack of consistency in how well the service was managed and led. There were pockets of good care, in particular in units which had experienced and enthusiastic staff. For instance, a member of staff told us, "There is a good atmosphere on this floor. The girls are so good at what they do. We all work together and help each other out." However, this positive teamwork and atmosphere was not evident across the whole service.

We observed the daily meeting which was attended by the head of each unit and other key staff and managers, including the cook, domestic and activity person. At the meeting we attended there was a discussion on the refurbishment of one of the units and the organisation's vision statement and charter. The meeting was also used to discuss key issues relating to the care of people living at the service, which included feedback about a person's hospital admission, new people moving in and the activities on that day. Notes were produced after each meeting so the manager could have an oversight of the main issues and activities on each particular day. We felt that this was a useful and positive meeting however we found there was a gap between what we heard at the meeting and what we observed and were told about the service from a large proportion of staff, people and families. For instance, staff felt they were not always aware why decisions were made about people's care.

The staffing issue in the nursing unit provided an example of the difficulties we observed with communication within the service. The manager had given us a clear rationale for the initial decision to take out the senior carers from the Valentine unit, and explained that this gave the care staff an opportunity for promotion within the service. A number of staff across the service told us however they were unaware of the reasons why this change had taken. Staff said they had raised their concerns about staffing levels to the manager but felt nothing would be done about this. The manager was able to show us plans that demonstrated that feedback from the staff had been listened to and the senior carer role was being re-instated, however this positive message had not filtered down effectively to front line staff. As a result some of them remained concerned about this issue.

We found the registered manager to be very open and cooperative to our inspection team throughout our visit. They were very visible downstairs in the communal part of the building, for example they were frequently seen talking to families and people in the coffee shop on the ground floor of the service. Some people and staff told us they were approachable, for example, a member of staff told us, "[Manager] is lovely, you can talk to them." However, some staff and families told us they were not as visible elsewhere in the service. For example, when a person told us about a poor experience of care they said the manager had addressed this with the staff on the unit, however they told us, "The manager is hardly ever here (on the unit) though, and the girls know that."

Some people said that they did not feel there had been any change as a result of talking to the manager about concerns about the lack of staff and the high turnover of staff. One relative told us the manager, "Says all the right things, but there's no follow through." In contrast, a social care professional referred to the manager's solving concerns relating to a person's individual care and told us, "The manager seems to make

things happen."

The manager explained to us that they were aware of difficulties within the staff team which needed resolving and they had dealt pro-actively with these concerns as some staff who had been performing poorly were no longer working at the service. We did not feel however, there was a consistent approach to managing poor practice. For instance, we saw positive examples where workers had received additional training, for example where they had failed their probation. However, we noted that monitoring of staff who presented concerns in relation to their morale and attitude was sporadic and lacked focus. This meant issues were affecting the whole service were not being addressed in a consistent, structured way.

There was a positive focus on the appearance of the service and in creating a pleasant experience and living environment for people. There was a hospitality services manager responsible for housekeeping, which included the laundry. Several people asked us to highlight the efficiency of the laundry system. One person told us, "Laundry is taken in the morning, and often it's back the same day – I think they do a great job."

We noted during our visit however, a lack of management oversight in relation to people's more complex health and care needs, especially in the Valentine unit. Despite detailed action plans in place highlighting areas of concern which mirrored our concerns and the employment of qualified nurses of a good quality, we felt that the overall management of clinical issues within the service was not of an acceptable standard.

Roles were not clearly defined in relation to clinical governance. For example, the clinical lead told us that they looked over some of the charts detailing the care being provided to people but that it was the responsibility of the nurses and senior carers to check these were completed correctly. The manager advised the clinical lead was responsible for overseeing staff practice in relation to meeting people's health care needs. However, we found that the clinical lead had not dealt effectively with the lack of consistent monitoring of people's needs. Likewise, they had not recognised and addressed immediately the delays and potential for errors in the administration of medicines which had resulted from the changes in staffing in the nursing unit. When we discussed our concerns with the clinical lead, they acknowledged the issues we raised around the lack of clinical oversight and the potential impact on people's health.

We also discussed our concerns with the registered manager who told us the clinical lead had necessary skills to help develop a high quality dementia service. We were advised one of the area managers was a qualified nurse and visited the service to provide additional clinical advice and guidance. Despite a number of positive improvements introduced by the area manager, there remained a gap in the daily clinical management of the service which had not been effectively addressed by the registered manager.

The provider had a number of audits which were detailed and wide ranging. The registered manager showed us a very detailed management action plan which included actions resulting from audits by the senior area manager, which had picked up many of the concerns we had raised. For example, there were required actions to deal with the gaps in the records showing how often people being cared for in bed had been turned. Whilst this was positive, we noted that the regular ongoing checks in place at the time of our visit had included looking at these records but had failed to pick up the concerns we had found. Likewise, the action plan required the manager to 'Develop and maintain an individual training and development plan for each team member, showing how the outputs of supervisions and appraisals are feeding into the person's individual development.' This had been signed off by the registered manager; however, although a chart had been set up showing when supervisions were arranged, these meetings were not always used as outlined in the action plan.

The registered manager had failed to ensure the effectiveness of the systems which were in place to monitor

and mitigate the risks relating to the health, safety and welfare of service users. This was a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received feedback from a number of people and staff about the impact of staffing on morale. For example, a member of staff told us, "I haven't had a break since I started first thing this morning," and we saw that it was 2.30pm. A person told us, "Staff very often get taken to another floor, they get very cross about it." We discussed with the manager the high turnover of staff and the negative morale we had observed in different areas of the service. They told us it was a slow process but staff morale was starting to improve. An awards night for had recently been held for staff, with people who used the service and families involved in voting. Staff who had performed well were also selected each month to join the 'Hall of Fame.' The manager had arranged for a representative from the provider's human resources department to meet with senior staff every month to support them implement the necessary changes in their units.

The provider ensured the manager had access to current information and circulated a newsletter to all its services which informed registered managers of new policies and any best practice information. There were also annual conferences attended by the registered manager which provided a support and information sharing network. We saw evidence of positive changes being introduced with the support of the wider organisation for example; the manager told us they were putting a new café into the dementia unit following feedback from families that they were not taking their relatives downstairs to the main café. We were also told by the manager that an electronic care plan system was being introduced to work alongside the existing electronic medication system. It was felt that this would free up staff time which they could spend directly supporting people. Though our observations indicated that the measures the manager had put in place were not yet showing concrete results, the initiatives being introduced demonstrated a positive commitment to resolving the concerns which we had found in during our visit.

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 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to ensure the effectiveness of the systems which were in place to monitor and mitigate the risks relating to the health, safety and welfare of service users

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager had failed to ensure there were sufficient numbers of staff to meet people's needs and keep them safe.