Tamaris (England) Limited

Amelia House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place over five days on 30 November, 4 December 2017, 9 and 31 January 2018 and 1 February 2018. The first inspection day was unannounced and we told the manager we would be returning to the home on 4 December 2017. The third day of inspection was unannounced and was in response to concerns we had received following the previous inspection days. We returned to the service on 31 January 2018 and 1 February 2018 in response to information of concerns we received about the service.

At the inspection in October 2015 we judged the service to be Requires Improvement in Safe and Good in all other areas. There was no breach of regulation at this time but we recommended that staff deployment and the use of agency staff was reconsidered to ensure that staff were always visible in the home.

Amelia House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide accommodation and care for up to 81 older people, some of whom are living with dementia. At the time of our inspection there were 71 people living at the home. The home is divided into three areas: Appleton (general nursing), Bancroft (dementia residential) and Carlton (dementia nursing). The accommodation was on three floors with a passenger lift to connect all areas of the home.

The service is required to have a registered manager in post and on the first two days of there was a manager in post who had not yet registered with CQC. This manager subsequently left. From the third day onwards there was an acting home manager in post who was not registered with CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that there were breaches of five of the fundamental standards of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, safeguarding, staffing, recruitment and the overall oversight and governance of the service.

Measures which were required to reduce the risk of harm to people were not in place.

Although the registered provider had systems in place to monitor the care being delivered to people these were not effective in ensuring people were provided with safe care.

Staff recruitment was not consistently robust. We saw one member of staff had been recruited to a senior role despite the registered provider being aware of a poor reference from a previous employer.

Because of our concerns about people's care and treatment during the inspection, we made six individual safeguarding referrals to City of York Council. We will monitor the outcome of these investigations.

The provider had systems in place to protect people from avoidable harm however staff had not consistently followed these.

The provider had not ensured staff received the support, training and supervision they required to deliver effective care.

We saw care staff tried their best to deliver a good standard of care and we saw they were compassionate and kind towards people. However, this was not based on effective leadership, record keeping or management oversight.

Care plans contained conflicting information and monitoring charts associated with care plans were inconsistent so were not an accurate record of care provision. This meant there was no guarantee that people were receiving care that met their current assessed needs.

On the general nursing care and dementia residential care unit it was clear that staff knew people well and this helped them to provide person-centred care.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate enforcement action, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Measures which had been identified to reduce the risk of harm to people were not in place.

Staff recruitment was not safe. Staff had received training on safeguarding adults. However, staff were not consistently following the systems in place to report allegations of abuse.

Medicines management was robust. The home was clean although some minor repairs were required to promote effective prevention and control of infection. Essential safety checks had taken place.

Is the service effective?

Requires Improvement

Staff had not been provided with regular supervision and had not received all of the relevant training to support them in their roles.

People were being deprived of their liberty without the required safeguards in place.

Staff sought consent from people before providing support. However, people's capacity to make decisions had not been consistently assessed.

People had access to health care professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although staff were kind and compassionate we saw some examples of care which showed a lack of understanding of people's needs.

Care staff were trying their best to deliver good care but the lack of effective leadership and modelling of good care impacted on this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

People had care plans in place that described their individual support needs but some information was conflicting and some monitoring charts had not been completed consistently.

A variety of activities were provided by both activities coordinators and staff.

There was a complaints policy and procedure in place and complaints had been investigated appropriately

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of effective management oversight at the home.

Audits had identified some areas of concern but they had not ensured that improvements were sustained.

The provider had failed to identify the concerns we saw during our inspection.

Amelia House Care Home

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 checked 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 was a comprehensive inspection that took place on 30 November, 4 December 2017 and 9 January 2018. The first day was unannounced and we told the registered provider that we would be returning to conclude the inspection on the second day. The third day of inspection was unannounced. On 31 January and 1 February 2018 the inspection was continued. This was in response to information of concern which was received about the service. We told the registered provider we would be returning.

Day one of the inspection was carried out by three inspectors, a specialist 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. Day two of the inspection was carried out by one inspector. The specialist advisor was a registered mental health nurse (RMN).

Day three of the inspection was carried out by two inspectors, an assistant inspector and a specialist advisor. The specialist advisor was a registered mental health nurse (RMN). Day four of the inspection was carried out by two inspectors from lunchtime onwards. Day five of the inspection was carried out by three inspectors.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider was asked to submit a provider information return (PIR) before this inspection. The PIR 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. The PIR was submitted within the required timescale.

The inspection was prompted in part by notification of an incident following which a person using the

service sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. This inspection examined those risks.

In addition to this, the local authority had issued the provider with a formal improvement notice due to recent concerns they had received and looked into. These concerns were considered as part of this inspection.

During the first two days of the inspection we spoke with nine people who lived at the home, eight members of staff, eight family members/visitors, the manager, the support manager and the regional manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and induction records for three members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

On the third day of inspection we spoke with two people who lived at the service and a relative. We completed a SOFI. We looked at six care plans and looked at medicines for four people. We reviewed staff files.

On the fourth and fifth days of inspection we spent the majority of our time on the dementia nursing unit and reviewed care plans and associated records along with staff files and discussed the running of the service with the management team.

Inadequate

Is the service safe?

Our findings

On the fourth and fifth days of inspection we identified a number of people living on the dementia nursing unit who were at risk of harm because measures which had been identified to reduce the risk of falling had not been put in place. The measures included sensor mats which would alert staff to the person mobilising and anti-slip mats to reduce the risk of sliding from a chair. Inspectors had to intervene and prompt staff on duty to take action to keep people safe. Despite identifying these concerns to the management team when we returned the following day we found the measures were not in place. This meant people were at risk of ongoing harm.

On the fourth day of the inspection we reviewed the records for one person who had been identified as being at high risk of falling. They had fallen three times in the last month. One of these falls was from their wheelchair whilst being transferred from the lounge to the dining room. This occurred as a result of staff not fastening the lap strap in the person's wheelchair. The acting home manager told us the staff member involved was an agency member of staff and was not aware of the need for this. The regional manager told us they had put measures in place to ensure agency staff knew people's needs.

We saw they should have been sat on a specific piece of equipment to reduce the risk of sliding from their chair. When we checked this with a member of staff we saw this was not in place. The staff member provided this. However, when we returned the following day the equipment was not in place. We spoke with a member of care staff who told us they could not find it. We raised this issue again with the acting home manager and the regional manager.

We reviewed the daily records for a second person and saw they had been found on the lounge floor following an unwitnessed fall from their chair. There was no documented evidence to say that medical attention had been sought following the fall. The accident form which had been completed stated the person had sustained an injury but there was no body map recording this. There was no evidence any observations had taken place to ensure the person had not suffered any ill effects following the fall. The acting home manager had recorded on the accident form that the person's care plan and risk assessment had been updated when in fact it had not. The acting home manager told us staff on the unit assured them this had been done.

Records we reviewed for three other people identified they also needed sensor mats to be in place. A sensor mat is a piece of equipment which alerts staff if the person is no longer sat on the mat and is used as a way to reduce the risk of falling. We saw care records for a further three people that identified the need for sensor mats to be in place. All three people were assessed as being at high risk of falls. When we checked we found the sensor mats were not in place which meant staff would not be alerted when they mobilised putting them at risk of further falls.

We identified people were at ongoing risk of harm. We shared our observations with the acting home manager and the regional manager. We also made individual safeguarding referrals to City of York Council (CYC).

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were able to describe different types of abuse and told us they would report any concerns to the manager we identified two safeguarding incidents recorded within daily notes. Staff had not recognised or reported these as safeguarding issues. Therefore, the systems in place to protect people from harm were not being followed. We were already aware that the police were investigating an allegation of physical and verbal made against a member of care staff.

On the third day of our inspection we observed a member of staff assisting a person to eat their lunch. The person was having a drink and the member of staff took this away from them and continued to assist the person to eat despite them making it clear they didn't want anymore. This observation was shared with the acting home manager and regional manager who agreed to investigate the matter. We also made a safeguarding referral to CYC. We followed up these concerns with the acting home manager on the fifth day of our visit and were told there had been no amendment to the staff member's duties. Therefore the risk remained.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they would use the home's whistle blowing policy and were confident the information would remain confidential. A whistle-blower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

We checked the recruitment records for four members of staff. These evidenced that a Disclosure and Barring Service (DBS) check was in place prior to them commencing work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. The records for nurses had been checked to ensure they were registered with the Nursing and Midwifery Council and there was a record of when their registration was due for renewal.

The provider had been aware of an unsatisfactory reference which had been provided for a senior member of staff, for another role within the organisation. They had not taken steps to adequately address this. This meant the provider was not completing robust recruitment checks to ensure staff were suitable for the roles in which they were employed.

A reference for another staff had not been returned and the manager assured us this would be followed up. In respect of agency staff the manager told us, "We rely on the agency to vet and check their staff in line with national good practice and they assure us they do." The provider should have systems in place to check that the information provided to them by employment agencies is accurate, and that agency staff have the correct safety checks in place.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in October 2015 we recommended that staff deployment and the use of agency staff was reviewed to ensure that staff were always visible in the home. This had continued to be a concern since the last inspection. At this inspection we received differing feedback from people about staffing levels.

Comments from relatives included, "Seems to be enough [staff]", "I notice the carers chatting to all the residents. [My relative] is never left alone for very long", "There are always staff around. They usually sit in one of the spare chairs" and "Not always enough staff – lots of agency staff on weekends and the regular staff have to 'carry' them." Everyone who lived at the home told us there were enough members of staff on duty, apart from one who said, "There aren't enough. I can't do anything for myself at present. If I want to go to the toilet I press the alarm and I have to wait. Sometimes they tell me to wait a minute which upsets me as I can't wait."

On the first day of our inspection the manager told us, "One of my priorities is to become fully staffed with competent and committed nurses, and this process well under way." They had recruited four full-time care workers, one full-time night care worker and one bank nurse, who would commence work when recruitment checks were in place. A new nurse had already commenced work at the home and another nurse was working through their induction training. Two other prospective staff were awaiting their interviews. In addition to this, they had reduced the number of employment agencies used from four or five to one. This allowed them to use two nurses and three care workers on a regular basis to promote consistency. Despite this the regional manager told us the home had 462 hours of care vacant per week which meant a reliance on existing staff completing additional shifts, bank staff from the organisation or agency staff. We saw the use of agency staff had reduced.

On the third day of our inspection the acting home manager told us the core staffing levels were, one nurse and five care workers on Appleton (general nursing unit), one senior care worker and five care workers on Bancroft (dementia residential unit) and one nurse and five care workers on Carlton (dementia nursing unit). However, the regional manager explained that as each unit had a number of vacancies the number of care workers could be reduced from five to four on each unit, they told us the acting manager would keep this under review and amend staffing levels as required. During our inspection we saw there were sufficient staff numbers to meet people's needs. However, we were concerned about the lack of a consistent stable staff team on the Carlton unit. The acting home manager and regional manager were aware of the need to ensure stability and were taking measures to manage this by rotating staff from other areas of the home and recruiting new staff.

Despite the concerns we identified people told us they felt safe living at the home. One person said, "I like it here as I can keep my door open and there is always someone about, and they check in on me." Most relatives told us they felt the home was safe for their family member. One relative said, "Staff are attentive and always checking on my relative. They are very approachable." However, another relative told us about incidents that had occurred involving their family member which made them feel the home was unsafe. We were aware of these incidents and that they were being investigated by the local authority safeguarding adult's team.

Accidents and incidents were recorded electronically. Staff used the home's iPad to record incidents and the system automatically alerted the manager and senior managers that this information needed to be reviewed. Incidents were categorised so that appropriate people could be informed and appropriate action could be taken, such as making a safeguarding alert or seeking advice from health and social care professionals. These records were also checked by senior managers within the organisation, and then discussed at health and safety and governance meetings.

We saw the hairdressing salon contained heated tongs and hair products; these had the potential to cause harm through the risk of burns or ingestion. In addition to this, we saw that disposable gloves were on display meaning they could be accidentally ingested by people who lived at the home. The manager assured us that the salon door should have been locked and they would ensure it was in future, and that

they would arrange for personal protective equipment to be easily accessible to staff but stored out of reach to people who lived at the home. When we returned on the third day we noted disposable gloves were stored safely.

We saw that medicines were stored safely, obtained in a timely way so that people did not run out of them, administered on time, recorded correctly and disposed of appropriately. One clinical treatment room was cramped and there were plans in place for this to move to a larger room in January 2018. Only senior staff had responsibility for the administration of medicines and we saw evidence of their training. The manager told us that nurses were required to complete medicines training at foundation, intermediate and advanced levels, and that they also had competency checks.

Essential safety checks had taken place. There was a gas safety certificate in place and the emergency call system, hoists and slings, the passenger lift and the electrical installation had been serviced. The manager had produced a fire risk assessment action plan and we saw that most actions had been completed. The fire alarm system, emergency lighting and fire extinguishers had been serviced. Fire drills had taken place although these were infrequent and in some instances staff responses had been slow. Weekly and monthly fire safety checks were carried out by the home's handyperson but some were inconsistent. The manager told us these areas would be addressed.

There was a business continuity plan that provided advice for staff on how to deal with unexpected emergencies, and each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises.

Everyone we spoke with told us the home was maintained in a clean and hygienic condition and we observed this on the day of the inspection.

We noted that the home had received a food hygiene score of two, which is a low score. The inspection had been carried out by the health and safety team of the local authority, and checked hygiene standards and food safety in the home's kitchen. The manager told us the required work had been completed but the health and safety team had not re-visited the home.

Requires Improvement

Is the service effective?

Our findings

Care staff provided support to people with complex needs as a result of their dementia. People living on the dementia residential and dementia nursing unit displayed behaviour which could pose a risk to themselves and/or others. Despite this staff had not received specialist dementia training or training in how to identify and respond to signs of distress. We could not be assured that staff had been provided with the support they required to deliver effective care.

A care worker had been dismissed during their probationary period due to their conduct. They reported in their disciplinary meeting that they did not understand how to support people with dementia and had not had an induction or training to support them to provide effective care. When we reviewed their staff file we could not find documented evidence to say an induction had been completed.

Records showed that staff supervision meetings had not been consistent for everyone who worked at the home. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs. The organisations policy stated supervision should take place six times per year and stated, 'It is a two way process to monitor the provision of service and help staff development.'

Where supervision had taken place the records we reviewed showed these were to discuss specific issues such as use of mobile phones and completion of accurate records. They were referred to as 'flash' supervisions and did not provide either staff or the supervisor with the opportunity to discuss any specific concerns. One member of staff told us they did not feel supported and said, "Supervision is when you get told off." This showed a lack of understanding of the process of supervision by staff and managers.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Despite these concerns one member of staff felt the situation was improving and said, "I love my job, get regular supervision and appraisal now, and plenty of on-going education is now the norm. It was not so in the past." Although most people's e-learning was up to date, there were gaps in training for moving and handling and fire safety, and this meant people had been at risk of receiving support from staff who were not fully competent. However, on the third day of our inspection we found this training had been provided.

The manager confirmed that new staff who started work at the home completed moving and handling and fire safety training before they commenced work or on their first day at work. They were then required to sign up for the home's e-learning. This included; medicines, safeguarding, Mental Capacity Act (MCA), basic life support, Deprivation of Liberty Safeguards (DoLS) moving and handling theory, dementia, pressure ulcer care, equality and diversity and health and safety. A small number of staff had completed training on equality and diversity, challenging behaviour and person-centred care. Twelve staff had achieved a National Vocational Qualification (or equivalent) at Level 2 or 3 and one member of staff was working towards this award at Level 5.

The manager also told us that any new care workers would be completing the Care Certificate. This would ensure that new staff had received a standardised induction in line with national standards. Nurses had a 12 week induction programme that was based on the Care Certificate and the preceptorship in nursing; preceptorship is an individualised period of support under the guidance of an experienced clinical practitioner which attempts to ease transition into professional practice or a new role. There were two nurse mentors to support new nurses through this programme.

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

During day four and five of our inspection we identified six people living on the dementia nursing unit who were deprived of their liberty without the required DoLS applications being made to the supervisory body. The recording system which was in place to monitor DoLS applications was not up to date and the management team were unable to provide inspectors with accurate information.

This was a breach of Regulation13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans recorded that people lacked capacity to make decisions, but it was not always clear how this conclusion had been reached. There was evidence that some people had been assisted to make decisions in their best interests, such as remaining at the home on a permanent basis. However, in other care plans there was a lack of evidence about how decisions had been reached that were in the person's best interests.

When people had a lasting power of attorney (LPA) appointed to act on their behalf, this was recorded in their care plan. However, there was sometimes no documentation to evidence this. A LPA is a legal document that lets people appoint one or more people to help them make decisions on their behalf.

We recommend that records accurately reflect the support people have received with decision making and that care plans include evidence of people who are legally able to make decisions on another person's behalf.

One person had been supported by an Independent Mental Capacity Advocate (IMCA). IMCAs support and represent people who lack capacity in respect of decision making.

We received varying feedback about meals provided at the home. Comments included, "Sometimes brilliant, sometimes not so good" and "It's not bad. I prefer salads but we don't get them often." We observed the lunchtime experience and it was apparent that staff encouraged this as an opportunity for people to socialise. People were offered a choice of food and drink; overall they were supported by staff and allowed to eat at their own pace. One person did not want either of the choices on offer; they asked for a salad and this was prepared for them. Staff provided a choice of hot and cold drinks and snacks mid-morning and mid-afternoon. Various snacks were offered to people.

On the third day of our inspection we observed the lunchtime experience for people living on the dementia nursing unit. Although people did not have a long wait for their lunch to be served some people became distracted and then began to shout out. We had noted a number of incidents of distress had been recorded between people living on the dementia nursing unit around mealtimes. We spoke with the acting home

manager and the regional manager about this and they agreed to observe mealtimes and consider alternatives to reduce people's distress.

There was a notice in the entrance area asking relatives to let a member of staff know if they had brought food or drink into the home for their family member. This was to assist staff in monitoring people's nutritional well-being.

People's special dietary requirements and their likes and dislikes were recorded in their care plan. The chef had a list of people's special dietary requirements in the kitchen although they felt they were not always informed promptly when new people moved into the home.

Most people required some assistance with locating areas of the home. We saw that bedroom doors were painted in different colours and had room numbers on them, and directional signage was in place. This helped people to find key areas of the home. The manager told us they recognised the home was 'tired' in areas and in need of redecoration. They said that redecoration would be in line with the dementia framework and good practice guidance in respect of colour contrasts and materials used to support people who were living with dementia. There was an enclosed garden space with seating where people could spend time outside.

Requires Improvement

Is the service caring?

Our findings

A lack of consistent staff and clinical oversight, on the dementia nursing unit, meant knowledgeable staff were not provided in sufficient numbers and there was a lack of direction and leadership required to deliver consistently good care. Despite this we saw staff were kind and compassionate towards people.

Although we saw some examples where staff were kind, patient and familiar with individual's needs and choices, we also saw some examples on the dementia nursing unit which demonstrated a lack of understanding of peoples care needs. On the fourth day of our inspection we saw one person's care plan recorded they were diabetic however staff on duty were not aware of this. The chef told us they provided a diabetic diet however, staff were not aware of this and we observed the same pudding was eaten by everyone on the dementia care unit.

During our observations, including our SOFI inspection, we noted staff respected people's individual choices and preferences in a compassionate and caring way. We could see that people dressed in their chosen style. Appropriate humour and touch was used and people seemed to be familiar and trusting of those caring for them. One person told us, "They really care. They are funny and they know me by name." Relatives gave positive feedback about the caring nature of staff. One relative said, "The staff are great. They do fundraising before Christmas to make sure everyone has a gift and last year there was so much money everyone got more than one present. I also know about a resident who hadn't been outside the care home for a long time and a carer came in on their day off and took them to a coffee shop. Some of the younger ones go over and above."

Despite this one person raised concerns with us about the approach of staff in respect of their relative. They told us they had seen staff become 'exasperated' and had not always responded in a compassionate way to the way their relative expressed their distress.

We asked people if they were treated with dignity and respect by staff and everyone gave positive responses. One person told us, "They always close the door and leave you for a while when you are using the toilet." Relatives told us, "Definitely, they are very good. I saw them shower [my relative] just yesterday and they were very respectful of their privacy by covering them with a towel" and "The regular staff are very compassionate and [my relative] said they are happy and settled here." Staff described to us how they protected people's privacy when assisting them with personal care, such as closing doors and curtains and keeping people covered to protect their modesty.

Staff told us they encouraged people to maintain their independence, especially in respect of their personal care. One person told us, "They keep checking if I am alright and ask if I can do something myself, but help me if I can't." We saw staff were very patient with one person when encouraging them to walk rather than using a wheelchair. Some people had special cutlery so they could eat independently.

People were supported to keep in touch with family and friends. Relatives confirmed they were able to visit at any time and were always made welcome by staff. One relative said, "I was shown around by two

members of staff before [my relative] came here. I have always been made welcome."

We saw that written and electronic information about people who lived at the home and staff was stored securely to protect people's confidentiality, although we saw that some cupboards containing archive records were open. The manager told us these cupboards should have been locked and they would ensure this was the case in future.

We concluded the delivery of care was reliant on individual members of the staff team, who knew people and demonstrated a commitment to caring for people. It was not based on good leadership, systems and record keeping which would enable the registered provider to assure themselves they were delivering good quality care or to improve the service provided.

Requires Improvement

Is the service responsive?

Our findings

A care plan had been developed from the person's initial assessment; information gained from relatives and with the involvement of health and social care professionals (when needed). A folder of information recording people's participation in activities and support with personal care was held in their bedroom. This meant the information was accessible to the person and their relatives. A relative told us they felt this showed the home did not hide information and they were open, as it was there for family and friends to read.

Assessments included the use of recognised assessment tools for pressure area care and nutrition. Care plan topics included personal hygiene and dressing, psychological/emotional needs, infection control, communication and cognition. Care plans also included information about people's daily routines and their preferences for care. Some relatives and friends had produced information about the person's previous lifestyle, interests and family relationships. Staff told us that this provided them with information that enabled them to be able to provide person-centred care, although staff said more information would be helpful. One relative told us, "Staff know [my relative] and know what they like."

On the first two days of the inspection we found that some monitoring charts associated with care plans were not being completed consistently. For example, one person required two hourly positional changes to reduce the risk of pressure sores developing. On occasions the monitoring chart had gaps of three, four or five hours. Hourly checks to ensure that bed rails remained in place and safe were more consistent. We looked at the monitoring forms for one person on oral care and pressure mattress/cushion settings. Both forms had been completed on only six or seven days out of 30 in November 2017.

We found some anomalies in care plans. One person was supported at the end of their life but there was no end of life care plan in place to record their wishes. This had been identified by the manager who told us that these plans were now being completed for everyone when they moved into the home. Two care plans indicated that religion had always played a large role in the person's life, yet there was no indication that this had been taken into consideration when providing care. Another person's care plan recorded that they had a pressure sore. We were told that their pressure sore had healed, but it was difficult to determine this from the care plan records. There was a 'personal hygiene record' form in use to record the support people needed with personal care. However, it was not clear whether the form recorded the assistance people required or the assistance that had been provided. Some body maps did not correspond to other care plan records and the manager told us the decision had been made to re-train all staff on the completion of body maps. The regional manager has issued a directive to inform staff that body maps need to be completed for everyone who lived at the home each Sunday to ensure these were kept up to date.

Some people had been prescribed medicine to reduce anxiety on a PRN (as required). We saw that one person's care plan contained useful information for staff on how to reduce their distressed behaviour. However, this was written on a sheet of paper and had not been fully incorporated into the person's care plan, so it was not clear whether staff had read the information.

One person had been distressed and had been involved in some incidents which placed themselves or others at risk of harm. On the third day of our inspection we spoke with the acting home manager who explained their needs were being met on a different unit within the home and the incidents of distress had reduced. The acting manager told us it was their view the person should have moved straight into this unit but there had been no vacancies. They said they had discussed the move with the person's relative however there was no record of this discussion or record of how the decision to move had the person had been made.

This meant accurate and contemporaneous records were not being kept in respect of the care people received and decisions about changes to care were not always recorded.

This was a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care plan we reviewed contained very detailed guidance for staff about how to support a person who was living with dementia when they became distressed and posed a risk to themselves or others. Throughout the third day of our inspection we saw staff following this plan and providing the person with support which kept them safe.

Throughout the inspection we saw engagement between people who lived at the home and staff. There were three activities coordinators employed at the home; two full time and one part time. The activities coordinator and staff introduced painting, skittles, ball games and singing in lounge areas. Staff were singing Christmas songs, clapping and dancing, and encouraging people to join in. A relative told us, "We have PAT dogs that visit. That is brilliant – we all love it." Pets As Therapy (PAT) is a national charity that provides therapeutic visits with pets to hospitals, hospices and care homes. Various events were listed on the home's notice board, such as a visit to a garden centre, a visit to see reindeers and a carol service.

There was information displayed throughout the home that advised people how to express concerns or make a complaint. However, relatives told us they would complain to one of the managers if they had any concerns. We checked the complaints and saw that most complaints made during the previous 12 months (both formal and informal) had been investigated and the complainant had been given feedback. This included an apology where appropriate. There were two complaints outstanding as the investigations were on-going. The organisation employed a complaints officer and they checked all complaints information on a weekly basis to ensure it had been dealt with in accordance with the home's policy and procedure. However, we were made aware of a complaint which had been made to the home manager. This had not been dealt with in line with the systems in place and the regional manager and acting home manager had not been made aware of this when the home manager left. We requested the regional manager respond to this complaint which was also being investigated by CYC safeguarding team.

Inadequate

Is the service well-led?

Our findings

The provider was required to have a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC to manage the service. Like providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service has not had a registered manager since October 2016.

A new manager had been appointed in September 2017 and was not yet registered with CQC. We were informed by the regional manager they had left the service in December 2017. From the third day of our inspection there was an acting home manager who had previously been the unit manager on the dementia nursing unit. Interviews were scheduled to recruit a permanent registered manager and a deputy manager. The regional manager was leading this process and assured us that service had been provided with continuous management cover.

The regional manager was providing daily telephone support to the acting home manager and was visiting the service weekly. In addition to this there was a weekly support visit from a resident experience support manager and an experienced registered manager at a nearby sister home was also offering informal support.

Despite this support there remained a lack of effective leadership and management oversight at the service. The inspection team found that systems and processes established to ensure people received a good standard of care had not identified the concerns we found.

Prior to the inspection we had been told that the local authority had issued the home with a formal improvement notice. The manager showed us the plan they had produced to monitor the improvements that were being carried out. Whilst this showed that some actions had already been completed, such as the reinstatement of staff meetings and a reduction in the use of agency staff. Other concerns remained; record keeping and inconsistent care planning, lack of staff supervision and training and general concerns regarding poor leadership within the service.

Although audits had been completed by the previous manager and the regional manager they had not identified the risks we saw in respect of the safety of people living on the dementia nursing unit.

The regional manager had completed monthly audits which looked at various aspects of care throughout the home. An audit completed in September 2017 by the regional manager identified poor record keeping in respect of the accurate completion of food and fluid charts. The audit referred to three records being reviewed for people living at the home, two of these showed that people had not eaten or drunk for a 17 hour period. The overall score of the audit was 68 per cent. The score improved in October and November. However, an audit completed in December 2017 gave the home an overall compliance score of 64 per cent. This meant despite the provider being aware of ongoing concerns at the home there was no sustained improvement being made.

It was difficult to obtain key pieces of information we would expect the management team to know. For example, they were unable to tell us who had Deprivation of Liberty Safeguard authorisations in place.

Although there were systems in place to report safeguarding matters and accidents and incidents we found these were not being consistently used. For example, we found incidents where observation records had not been completed following falls and we identified two safeguarding matters which had not been reported by care staff.

On day four of the inspection we reviewed a document which provided staff with key information about people. It did not contain information about risks to people or how staff should manage these. This was of concern due to the lack of consistent staff and management on the dementia nursing unit. This document was updated to reflect risks to people during the fifth day of our inspection.

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

Due to the seriousness of concerns identified during our inspection we wrote to the registered provider and requested an immediate action plan which was submitted in the requested timescale.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. We found that notifications had been submitted by the manager when required.

Relatives told us they were aware of relatives meetings but had not attended. We saw evidence that meetings had been held in April and September 2017. One relative told us, "I want to spend my time with [my relative] not in a meeting. They should think of other ways of communicating with relatives such as an emailed newsletter, or ask for suggestions and feedback that way."

There was an iPad system on display in the entrance area that invited people who lived at the home, visitors and care professionals to leave feedback. The records we saw indicated that this system was used by relatives and that the information was summarised and analysed by the manager and more senior managers on a regular basis. A document had been produced in the format 'What we asked / What you said / What we did'. This recorded that 151 comments had been made by people who lived at the home, 74 by relatives and 10 by visiting professionals. One area of concern identified was about staffing levels. The report recorded, '[Name of manager] is trying hard to stabilise staff and reduce the number of agency staff. [Name of manager] has an open door policy and is happy to meet with people outside of office hours at a mutually agreed time.'

Staff told us they attended meetings and we saw the minutes of the most recent staff and senior meetings. Staff told us they could raise issues, ask questions and made suggestions at these meetings. There was a list of staff meeting dates (one per month) for 2018 on the home's notice board.