Anchor Trust

Devonshire House

Inspection report

High Street
Cavendish
Sudbury
Suffolk
CO10 8AS

Tel: 01787283240
Website: www.anchor.org.uk

Date of inspection visit:
27 November 2017

Date of publication:
08 March 2018

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

This unannounced inspection took place on 27 November 2017. This was the first comprehensive inspection of this location since Anchor Trust became registered as the provider of this service on 09 February 2017.

Devonshire House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Devonshire House is registered to accommodate up to 69 people. On the day of our visit there were 58 people resident. There were 21 people living on Ryder unit. This is a specialised unit with adapted facilities for people living with dementia.

At CQC we have a named registered manager on records, but had been informed that the registered manager no longer worked at the service. We await an application for them to deregister. 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.

Devonshire House is a relatively new acquisition for Anchor Trust and this along with the changes in management mean they need to develop a clear vision and credible strategy to deliver high quality care and support at Devonshire House that involves all stakeholders. The lack of consistent quality leadership has led to the breaches found at this inspection.

We found three breaches in the regulations. Risks to people's safety and welfare were not robustly assessed. This was particularly in relation to supporting people with distressed behaviour that were living with dementia and also falls prevention. We observed altercations between people that went unnoticed and had potential to escalate. Guidance for staff was not clear to minimise risks and promote people's safety.

There were insufficient staff deployed consistently to meet people's needs. Managers at the service did not have oversight as to where people were within the service and how many staff were deployed and where they were working. There were examples particularly on Ryder unit where people were not supported appropriately. There were gaps in past the rosters despite managers using dependency tools to determine staffing.

The complaint systems in place did not effectively address people's concerns raised nor were they used to drive improvements. People were not supported by the provider to raise concerns when necessary. We found responses to concerns raised were not robust or individualised.

Overall the service people received was inconsistent. There was a lack of involvement of people in how the service was run therefore matters such as activities on offer and planning for end of life care needed further

development. Anchor Trust had recognised these shortfalls for themselves and had started to action some points. Additional management support had been drafted in. There were consultations in place about the development of the environment. Environmentally this was a pleasant place for people to live, but the Ryder unit needed development to enhance the experiences for people living with dementia.

Staff supporting people were caring and compassionate. They were dedicated and willing to support people the best way they could. Staff on the Ryder unit would benefit from enhanced training in dementia. People did receive access to good health care and had sufficient to eat and drink. Staff promoted choices and independence for people.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety and welfare were not always properly assessed and managed. This included measures relating to falls prevention and people with distressed behaviour linked to living with dementia.

Staffing levels did not consistently support people when needed.

People's medicines were managed safely.

Staff recruitment measures were acceptable and further improvements have been made.

Staff understood their obligations to report any suspicions where people were at risk of harm or abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive appropriate support or appropriate training in dementia to ensure they were competent to support people.

Staff understood the need to seek people's consent to deliver care. The deputy manager understood the Deprivation of Liberty Safeguards and when applications were needed to protect people's rights.

People had enough to eat and drink and were supported to maintain good health.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff were kind and compassionate to people.

Individual staff treated people with respect for their privacy and independence. However, as a whole the service was unable to be

as respectful as it should.

People were supported to express their views and make decisions about their day-to-day care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People lacked opportunities to join in meaningful activities that reflected their hobbies and interests. People did not always receive a personalised service responsive to their needs.

There was a system in place for managing people's complaints but was not effectively addressing concerns and being used to drive improvements within the service.

There was a lack of guidance, knowledge and confidence in how to support people at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Changes in the leadership of the service compromised consistency and a clear vision for developing the service that people, relatives and staff felt a part of.

Systems for monitoring the quality and safety of the service were not robust enough to ensure regulatory requirements were met and improvements made.

Some improvements were on going and not yet fully implemented and embedded to show sustainable progress in improving the quality of care people experienced.

Devonshire House

Detailed findings

Background to this inspection

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

We carried out this comprehensive inspection as the first inspection of the service since the change of provider to Anchor Trust. It was completed by one inspector, an inspection manager 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.

Before we visited the service, we reviewed all the information we held about it. This included concerns raised with us and information from the local authority and a Provider Information Return (PIR). A PIR is a form completed by the registered manager to evidence how they are providing care and any improvements they plan to make. We also reviewed statutory notifications made to us. These relate to information about specific events taking place in the service and which they have to tell us about by law.

During our inspection, we spoke with eleven people using the service and four relatives. We also spoke with the district manager, deputy manager, and eight members of staff from the care team, catering staff and housekeepers. We reviewed records associated with the care of four people, including daily notes, assessments of risks to which they were exposed and guidance for staff about the support each person needed. We checked records of recruitment for five staff, systems for managing medicines, and a sample of records associated with the quality and safety of the service. We looked around the premises and observed how staff interacted with people and supported them. We also received feedback from two health professionals.

Requires Improvement

Is the service safe?

Our findings

The safety of the service needed to improve. Risks to people's safety and welfare were not robustly assessed. Information was sometimes incomplete or inconsistent. There was not always clear guidance for staff to follow to minimise risks and promote people's safety.

This was particularly evident on the Ryder unit which supported people living with dementia and we completed observations. During our time there we saw four separate disagreements between people who lived there. The altercations were verbal in nature with people becoming angry. There were no staff interventions and these altercations went unnoticed. We reviewed the care records of people involved and found that they were lacking in guidance for staff about how to support people who could present behaviour that challenged. For one person we found that there had been several incidents of violence and aggression noted by staff. However, there was not a comprehensive risk assessment in place with a plan to potentially prevent this from happening or any stated de-escalation methods to be used. Another person had a 'positive behaviour plan' in place, but this was not a correct assessment. We found evidence in incident records that on three occasions the person had physically assaulted other people living at the service. The assessment said the person did not physically injure others. Therefore the guidance in place had not been effectively reviewed and guidance for staff was ineffective.

We observed a person who had injured an upper limb. This injury was sustained from a fall. The person had ill-fitting slippers and was stooped so low their centre of gravity was compromised. They were bending down and repeatedly re-arranging a foot stool. This went unnoticed by staff. The inspector present at the time chatted with the person and placed the footstool safely under a chair to prevent it being a trip or fall hazard to them. We looked at this person's risk assessment for falls and their prevention plan. It had been completed seven months previously, but had not been updated and revised since the fall that resulted in the upper limb injury. It did not take account of the person's posture or their ill-fitting slippers. This person was placed at on going risk. This concern was fed back during the inspection to service managers so that immediate action could be taken.

We were talking to a person who was being cared for in bed when a staff member arrived and offered them apple crumble. The person gladly accepted. The staff member realised they had forgotten a spoon, so went to fetch one. By this time the desert was going cold. When they returned the staff member had been informed the person could not have crumble as it was a choking hazard to them and offered a yogurt instead. This example showed that not all staff were aware of people's dietary needs and the risks this presented in relation to choking.

These concerns represented breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for Safe care and treatment.

We asked people about their safety at the service. One person said, "I believe staff know what they are doing, I have been hoisted out of bed, I feel quite safe, I think they do their job well. They are keeping an eye on my fluids too". A relative said, Yes my relative is safe in the hoist." We observed two staff using a hoist and noted

their practice was good. We checked the sling type and size used and this was the same as stated in the risk assessment. Risks related to moving and handling were well managed.

Equipment servicing and checks were in place relating to fire safety, gas, electrical supply, shaft lift and hoisting equipment. Therefore people could rely upon the equipment provided and the systems in place were checked.

Not all people felt there were enough staff to support them safely. For example, one person told us, "There is not enough staff. When I told the senior once she said it was fine. Let's say they work their socks off with very little support." Another person said, "There are times I don't think there are enough staff, but they do quite a good job." A relative said, "If I don't come in every day I'm not happy that's my relative is being cared for. I feel that if I wasn't here I don't know what would happen. The other day I went in at 11.30am and mum was sitting with black tea and a bowl of dry cornflakes, no milk, no spoon. What would happen if I wasn't here? Every day I go away and worry whether she is being looked after." A different relative said, "Staffing is very much reduced, barely enough to keep things running. It has all the potential in the world and it's a shame." We observed that people in the main communal areas did not have a call bell to hand, but a person explained, "There are always staff walking about so I can shout if I need anyone."

We observed that particularly on the Ryder unit there was not enough staff to support people living with dementia to meet their needs. The day of our visit there were three care staff and a senior working there, but managers believed there to be more and were not aware of the lack of staff working on Ryder unit until we fed back at the end of the day. We were told by managers there were 21 people residing in Ryder, but we counted 24 people having lunch. The list we were given of people's names and rooms amounted to 25 people on Ryder unit. There were insufficient staff to interact with people throughout the day and staff missed potential conflicts between people as described above. At lunch time the senior staff member had to accompany the GP who was visiting a person in their room and also answer the telephone and therefore was not wholly available during this busy time.

One person was distracting others by rapping a spoon loudly on the table, turning over a coffee table, blowing a whistle and strumming a guitar vigorously and needed greater support to focus on their meal. One staff member had to leave the person they were supporting to eat on four occasions to support others to eat. These examples show the impact on people of insufficient staff deployed effectively.

Managers told us they used a dependency tool. We saw that this took into account the numbers of people and their dependency levels of low, medium and high. There was also an environmental factor relating to how the service was laid out. The deputy manager said that the dependency tool was up to date and staff for the whole service worked out as 10 staff during the day and six at night. We looked back at recent rosters and found that as well as the day of our visit the service had ran short on staff on several occasions, both during the day and at night. Particularly on Sunday 19 November 2017 where three of the staff were agency as well as running one staff member short. Agency staff whilst providing cover cannot know people as well as permanent staff and therefore personalised care cannot always be achieved.

These concerns represented breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for Staffing.

Managers told us that recruitment was on going and they had completed several interviews and staff were on induction. We could see from the roster that staff were completing shadow shifts. We looked at recruitment records for staff. On the whole recruitment records were acceptable with references being sought and disclosure and barring service (DBS) being checked before staff started work. However, we found

that certain designations of staff such as housekeepers were not subject to checks on the 'barred list'. The barred list is a record of people who are not permitted to work in a regulated activity with children and/or vulnerable adults. It's a criminal offence for a person to work with a group from which they have been barred from working. There are three types of DBS (basic, enhanced and enhanced with barred list check). Anchor Trust had a policy of only checking the enhanced list without checking the barred list for some staff. Housekeepers and other staff not providing direct care had the potential to be alone with vulnerable adults for periods of time and therefore should have been subject to an enhanced disclosure with a barred list check, the same as care staff. Following inspection we raised this matter with Anchor Trust and have been told this had been an omission and was being rectified across all 130 of their homes.

Medicines were safely managed. One person told us, "I have medication, I'm not sure what it's for but I'm given it regularly." Another person said, "They come in the morning with my pills, the lady brings them in shortly after 9." Staff had undergone regular training in medicines administration with their competencies checked. Storage was secure, temperatures checked and stock balances were well managed. Medicines that needed additional storage measures were found to be safe and accounted for. Records were comprehensive and well kept. Body maps were used to monitor patches used to administer some types of medicine. Staff were able to tell us about medicines and their side effects and those medicines that were time critical to help keep people well. Staff were observed administering medicines appropriately. We saw staff explained to people what their medicines were for and asked people if they required any medicine for pain. They signed the medicine administration record after they had administered medicines. We saw that one person living with dementia refused their medicine. The staff member waited a while and asked a different staff member to offer the medicine. On that occasion the person accepted their medicine.

Staff told us that they were confident in administering medicines and the systems that were in operation. There were regular and effective auditing systems in place. Actions were taken to improve and develop medicines management and administration safety.

People told us that they felt safe living at the service. One person said, "I don't lock my door, I don't think it's necessary." A different person said, "I feel absolutely safe here, I can let my budgie out, I can lock my door". Another person said, "I don't feel any reason to feel unsafe, you are well cared for, no unexpected people popping about."

Staff knew how to identify and raise any concerns about peoples' safety. Staff had received safeguarding training and demonstrated an understanding of how to identify potential concerns and what to do. Staff were able to tell us who they would go to with concerns, or, what they would do, if they were a more senior member of staff. Staff were aware that the service had a safeguarding policy to follow and a 'whistle-blowing' policy. Staff told us that a copy was in the staff room for them to refer to if needed. When concerns were raised a manager notified the local safeguarding authority, or took advice from them and notified CQC in line with their policies and procedures and matters were investigated. Records were kept and available for inspection.

Lessons learnt and a culture of improvements and learning from incidents and near misses needed to be developed further. Whilst we could see that reports were made and key events were reported and dealt with, there was further room to ensure similar events were not repeated and escalated to a more serious level. These included events around managing people who displayed behaviour that was challenging and related to their dementia.

The premises were generally visibly clean and tidy. However, there was an odour of urine on the Ryder unit and a chair with no cushion. One relative said there were sometimes unpleasant smells in the Ryder unit. We

saw cleaning taking place during our visit. We spoke to housekeeping staff who told us that there was just enough time to get round and that a new system of cleaning had been introduced to help them get back on track. They were pleased to be getting new equipment and had training on the use of products to be used. The deputy manager told us that they had arranged for a deep clean of the premises. Staff had access to protective equipment such as gloves and aprons. Staff were able to describe how they prevented the spread of infection. Care staff demonstrated clear knowledge of how to manage a suspected or actual outbreak of infection in the home.

There were systems in place for the monitoring of Legionella disease. Hot water temperatures were monitored and we saw that action had been taken where these may have been too high and adjustments had been made to prevent potential scalding.

Requires Improvement

Is the service effective?

Our findings

All the people that we spoke with said that staff were trained, friendly and able to meet the needs of people. One person said, "I believe staff know what they are doing." A health professional told us, "Staff have the knowledge to answer questions when I ask. They are confident to follow our advice and try out what is suggested by us." Staff told us that they had the training and support they needed to carry out their role effectively. The managers had a computerised training matrix that allowed them to monitor any training updates that were needed. Current compliance of all staff training stood at 86%. This was mainly in the form of e-learning. This showed us that most staff had relevant up to date training in place. There was a staff member who had additional training in moving and handling and therefore was able to coach other staff. There was a staff member trained and able to deliver health and safely and fire training to staff.

We asked the deputy manager about dementia training for staff. They were unable to tell us what this consisted of but believed this needed to be evaluated and updated especially in relation to staff who worked on the Ryder unit. A dementia lead from Anchor Trust was visiting during our inspection to support staff. They were in the process of evaluating care plans. The previous registered manager had sent us information in the form of a provider information return (PIR). It told us that some staff had completed baseline training in understanding dementia and had become dementia friends though The Alzheimer's Society. Whist this was positive we would expect staff who worked on the Ryder unit or could be asked to work on the Ryder unit to have a deeper level of understanding. Staff on Ryder unit should have been able to support and manage people with distressed behaviour, know about positive behavioural plans and how to use these to ensure people had a sense of wellbeing rather that our observation of several people being distressed and argumentative with one another.

Records did not demonstrate that staff had received regular appropriate supervision and appraisal. This was an area already known about and a plan had been put in pace to address this matter. Staff spoken with confirmed that supervision was getting better and was more frequent. Staff spoke of morale improving and how they worked better as a team.

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 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. DoLS applications had been made to the local authority and authorised where appropriate. The deputy manager monitored these and said they had reviewed and applied for further DoLS authorisations for named people since they had started at the service in recent weeks.

Staff demonstrated they understood the MCA and DoLS and how this applied to the people they supported. Care plans recorded where other people had lasting power of attorney (LPA) and staff understood what this meant. People's relatives or representatives who had been appointed as a LPA for people living in the home in respect of people's care and welfare had been consulted and signed consent forms for care support in the

care plans. Care plans had evidence based best interest decisions documented with appropriate people consulted. One example of this was where it had been determined that it was in the best interests of a person to remain at Devonshire House and live in the Ryder unit.

Staff encouraged people to make decisions independently based on their ability. We observed that staff knew people well, and this allowed them to support people to make decisions regardless of their method of communication. An example of this was when a staff member was serving morning coffee in Ryder. They were offering people drinks, biscuits and had other snacks on the trolley. A person came over and was unable to express themselves verbally but took a yogurt from the trolley. The staff member noticed and said, "You want a yogurt, let me help you and get the lid off for you. Here is a spoon to eat it with." This showed that the staff member promoted choice and respected the decision of the person.

People's views about the food varied. One person told us, "The food is nicely presented, I've a list of what's coming, you can have one thing or the other." Another person said, "Dinner was fairly good, the food is good, adequate and regular". Whereas another person said, "The food is reasonable, one wouldn't say it was good, it's acceptable." Another said, "They used to have very good breakfasts here, but they have been missing the sugar for my tea for a few weeks." A relative said, "They are let down by a lack of attention to detail, things like people ordering a meal and its wrong when it arrives. It's inconsistent". A different relative said, "The food was awful, it's improved slightly but it's done for the majority. There's no finesse". One person who lived in the part of the home that did not support people living with dementia told us that on occasion they had been forgotten at supper time. This told us that work needed to be done to improve the meal experiences on offer so that the majority of people could provide positive feedback about their experience of the catering. The catering staff said they did have a comments book about food, but had insufficient time to meet with people and obtain their feedback.

The service's catering staff had responded to specialist feedback given to them in regard to people's dietary needs and had taken action to meet them. For example, by providing pureed food and introducing food that was fortified with cream and extra calories to enable people to maintain a healthy weight. The chef told us, "I do make diabetic cakes and puddings. I pipe the pureed food in separate portions which looks nice and I find potato pearls are good for thickening and they are fortified as well. I do a separate pureed pudding." We saw that these were well presented and looked appetising. This helped to ensure that people got the food they needed to stay well.

People were able to choose from a plated up lunch option, so that they could decide based upon what they saw and how they felt at the time. We observed the lunch time experience in both parts of the service. People who lived in the part of the home that did not support people living with dementia had a more positive experience. Knives and forks were placed in people's hands where appropriate. We saw that where people were not able to eat their meal unaided they were offered support to eat. In the dining room condiments were available on tables and people had napkins. This was not always consistently supplied for people who ate in their rooms. Where people were assisted with meals, this was done with kindness and patience and encouragement. People in Ryder unit did not consistently get the one to one attention needed to ensure they eat well and had a positive experience at mealtimes.

People were supported to maintain good health. One person told us, "I'm ridiculously healthy and they help me stay healthy." A different person said, "The district nurse comes once a week and changes my bandage for my leg ulcers. I do my exercises, I put my legs up." A person told us that they saw the chiropodist and the district nurse regularly and had done so for years. Another person told us in detail how staff supported them to manage their catheter and how they were encouraged to drink more. They said staff were good at changing to a night bag as needed.

Most relatives felt they were kept informed of health matters relating to their family member. One relative did however express their need to be vigilant about their relative's health needs. They were not confident that health care professionals would be forthcoming if they did not request staff to call the GP or access nursing visits. They confirmed that nurses and GP's attended when requested.

The service staff worked well with community health practitioners and ensured people had access when needed. A visiting health professional told us that they had a good relationship with staff and that requests for visits was appropriate. They said they knew who to communicate with, "I always relate to the team leaders and know who they are." A different health professional told us, "Staff are positive and welcoming. They do seek help from our service. They are open to take people with complex needs." An occupational therapist was visiting whilst we were at the service. They had come to assess an individual. The GP was visiting a group of people who had been referred that day. A person was being taken by their daughter to see a dentist. All this evidence cumulatively showed us that staff at the service worked well with other health professionals and knew who and when to refer concerns to as they arose. Records showed us that staff monitored people's health conditions well. Where required people had their bowels monitored or their skin monitored for breakdown and prevention strategies were in place.

The adaptation, design and decoration of the premises met people's needs. There was a planned program of redecoration with new floor covering included. People were being consulted and were helping choose the colours being used.

The building was suited to the needs of people living with dementia. The Ryder unit was built in a circular design so that people could move freely through the different areas. Further adaptations were planned the unit to make the environment better suited to people living with dementia. There was access to safe, well maintained gardens where people could access nature and fresh air safely. A relative said that the gardens were a great addition and were used well during summer. For security reasons and people's safety, there was a buzzer system to let people in and out of the Ryder unit. Both lounge areas were homely and comfortable. Seating in both lounges was arranged in small sitting room style giving a cosy feel.

Requires Improvement

Is the service caring?

Our findings

People told us that they were satisfied with the care provided. One person we spoke with said, "I think it's great here, better than living alone". Staff had positive relationships with people and showed kindness and compassion when speaking with them. Staff took their time to talk with people and showed them that they were important. For example, one person was going to the dentist and staff were reassuring them about what was happening. They gave information about when they were going and with whom. The staff member gently stroked the back of the persons head and gave a reassuring smile. One person said, "They are all very kindly, they are interested in what you do, they laugh with me." Another person said, "If I'm distraught they come and comfort me. I can't complain about anything at all".

When staff spoke with people they were polite and courteous. Relatives were complimentary about how staff treated their family members. One person told us, "Some of them are extremely pleasant". One person said "We are treated well."

People's privacy and dignity was not consistently respected and promoted. One person said, "Staff always knock, they are lovely here I've got no complaints. I've got everything I need here, they really are very good these people." One person said, "Staff are very good at personal care, it's always females, I don't like a man to fiddle around with me". This showed us that the person's choice to have female staff had been respected and their dignity preserved. One person did tell us, "They are quite willing, they wash me just about every day, sometimes I have a shower but not often. Generally speaking they are pretty good, there was a time they were very good, now I don't think they match up to before". Whilst we saw individual staff being caring there were examples such as; A person was talking to a staff member and their nose was running. This went unnoticed by staff. The culminated effect of staff not being supported through management systems, training provided or numbers of staff meant the service as a whole was not consistently caring of people.

Staff knew people well including their preferences for care and their personal histories. Care records had life histories completed for staff to read and learn about people's lives. One person told us, "They are all very kindly, they are interested in what you do, they laugh, my daughter brings her dogs in when she visits. I have a tray in here for all my meals. I'm living here very much as I did at home."

When we asked about people, staff were able to describe people's care needs and say how they preferred these to be delivered. One person told us that their personal care was regularly attended to. They went on to say, "At the moment I'm sleeping a lot, I was turned this morning. They are a good crowd." We observed staff supporting people in a warm and kind way. Staff responded to people in a friendly and supportive manner in a way which maintained their dignity. Staff told us that they tried to support people to maintain their independence as much as possible and assessed the level of support people needed all the time. One person told us about their level of independence, "I see to myself completely during the day. I am up early, one day I have a bath, a strip wash the next. I always clean my own teeth." Being independent was clearly important to them and staff supported this. Two other people told us about their levels of independence and how staff enabled them to do as much as they could for themselves. One person said, "You can do what you like here. I like to knit in my room."

People were involved about making decisions relating to their care and support. One person said, "Staff know what time I like to get up and go to bed and they come at those times." We observed staff asking people how they liked to be supported and respecting their decisions. Relatives we spoke with said that they felt involved in their family member's care and decision making when appropriate and they were made to feel welcome in the home. People could have visitors whenever they wanted and there were no restrictions in place. We saw records of people's care reviews and it was evident that family members had been involved and were able to express their opinions about the care their relative received. The deputy manager explained that relatives were being invited to come in for a new round of care plan reviews.

Requires Improvement

Is the service responsive?

Our findings

The service had mechanisms in place to routinely listen to people to improve the service on offer. However, this needed to be reviewed and improved upon. The PIR stated, 'We provide regular meetings and listen to what is being said, we respond in ways like using the "you said" "we did" boards.' These boards displayed feedback the service had received and showed what has been done to address the comments received. However, we did not see these boards in place at the time of our visit.

We examined the complaints policy. It did not have the details of CQC for people to tell us about their concerns. There was no record of complaints received in October and November 2017 even though we were aware that concerns and complaints had been raised formally. We saw the response to one person's complaint and this did not cover the points raised. We reviewed a second complaint and saw that this had the same response as the previous complaint, but had different issues raised. Therefore the system in place was not effectively addressing concerns and being used to drive improvements within the service.

A relative we spoke with said, "I have complained and it's being addressed apparently." They lacked confidence that things would change. One person told us that when they complained matters improve for a while and then would go back to how they were. Therefore people did not have confidence in the processes in place. We overheard a relative asking a staff member about a concern they had about their relative losing their false teeth for weeks and as a result had lost 6 lbs in weight. The member of care staff said they should speak to the senior on duty. The relative said they had, but that person knew nothing of the concern that they had already raised. The carer said they knew nothing about it either. We had to intervene and suggest that the member of care staff find the deputy manager and get them to speak to the relative to resolve their concerns. This lack of clear response and poor communication was mentioned by a number of relatives. One relative said, "One of the main problems here is communication, you tell staff things and it's never passed on."

These concerns represented breaches of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for Receiving and acting on complaints.

The service was not consistently responsive to people's needs. One relative told us, "One of my bugbears is the lack of personal interaction, I've been told if she wants anything she can ring her buzzer. You never see staff going into the rooms talking to residents. My relative is totally reliant on care and the care is not good enough". One person said, "They will help me wash if it's convenient, but usually its 'we are doing breakfast, we are doing this and that'. I used to have a shower everyday but it's difficult to stand, so I like a bath, I had one five days ago which is awful."

Some of our observation was that not all people received personalised care that was timely. One person was walking around with only one shoe on. Staff had not acted upon this which put the person at risk of an accident. One person during morning coffee was going round where people were seated having been served drinks with biscuits on the saucer and taking their biscuits and quickly consuming them. This went unnoticed by staff. In the Ryder unit as breakfast was coming to an end the cleaning staff hoovered the

dining area. The hoover used was so loud it was difficult for anyone to hear or talk in this area for some time. All these small events culminated in people not receiving a personalised service responsive to their needs and verged on being disrespectful.

People either came to the service on a trial basis or came for respite care before deciding whether to stay permanently. People had a pre-assessment completed prior to arriving at the home. This covered a range of people's needs and helped staff plan their care and for them to get to know the person. The provider information return (PIR) told us, 'Care plans are developed from the initial assessment and record information about individual likes, dislikes and care needs to enable staff to understand fully how to deliver care to individuals. To include encouraging and supporting independence in areas where they are able. We encourage the use of life histories to develop a person centred approach.' We saw that life histories were completed in the plans we examined. Care plans were kept secure. We could see that care plans were kept under review. Recently the dementia adviser within Anchor Trust had been reviewing care plans and making recommendations. One of the health and social care professionals we spoke with said, "They do take people for emergency respite and they do not pull the plug on people when it is challenging."

We found that not all care plans had consistently been completed in relation to end of life wishes. There was a lack of in depth knowledge displayed from senior care staff. They were aware of and had systems in place for those people who did not wish to be resuscitated, but staff were not confident or skilled to have meaningful discussions about peoples wishes and preferences, including treatment options at the end of their lives. A senior member of staff said that they had received some training from the local hospice last summer. One person spoke to us about how well staff had supported them at the end of their relative's life, "My relative had really good care when he was dying. Staff were so kind." They spoke about a memorial service being held at the local church and that this was important to them as was their regular access to church. We were told that the vicar visited people regularly. Further development was needed to ensure all people were supported to have a comfortable and dignified death of their choosing.

People were encouraged to follow their own interests. There were plans in place for a visit from the dementia support team within Anchor Trust to visit. They were planning to improve the Ryder unit to make the environment more interesting for people living with dementia. They were also planning to look at more tailored activities for people currently living there. Whilst on the Ryder unit we saw that one person was offered the opportunity to do some badminton for a short period and a staff member read aloud some poetry to a small group of people already seated together. There was little interaction or meaningful activity for those people who were walking around and some people were showing signs of distress. One relative said that she would like more music to be encouraged with Ryder. There was a guitar being played by one person living there, but it had only three strings instead of the six needed to play it tunefully.

People in the main part of Devonshire House consistently said that there were enough opportunities to follow interests and activities that suited them. One person said, "I spend my days mainly reading, listening to the radio, it's my health that's the problem." Another person said, "I draw, colour, read books that I can pass the time with. They do have activities, but I don't go, I'm 82 and don't want to jump around. I can always find something to do, if it's a nice day I'll go outside. I do get lonely, that's my only problem." Another person said, "There are no activities for me, sticking bits and paper, it's not me." A different person said, "There is a big list for Christmas activities, but we'll see, I've seen hardly any activities so far." We were aware of activities planned over the festive season, however, more consultation may be needed to ensure what is on offer is suitable for those resident to take part. We saw the hairdresser visiting and people who had their hair done were enjoying the social experience.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had recently left the employment of Anchor Trust. A replacement was being sought and an interim person was in charge but on leave on the day of our visit. There was a deputy manager who had very recently been appointed and had yet to fully understand the workings of the service and how Anchor Trust systems operated. Relatives had been informed at a recent meeting about the changes in management. There was varying views about knowing who was in charge with some people not knowing who the manager was or having been introduced. One person said, "The deputy has never been to introduce herself, there is never any management at weekends, the office is always in darkness." A different person at the service said. "We have new management, I think she's called [named the deputy], new staff always introduce themselves but not the high and mighty." Because of these changes and this service being a relatively new acquisition for Anchor Trust there was a need to develop a clear vision and credible strategy to deliver high quality care and support at Devonshire House that involved all stakeholders.

Anchor Trust had taken over the service and become the registered provider on 09 February 2017. We are aware that Anchor Trust had systems in place which continuously assessed and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents monitoring. However, we found that there had been some gaps in these records, specifically complaints. In relation to accident and incident records we found no records in place until August 2017. Relating to falls monitoring and prevention we found monthly audits in place for August and September 2017, but none for October 2017. We were not confident to state that the documentation showed that management took steps to learn from such events and put measures in place which meant they were less likely to happen again. These factors and the breaches we have found during our inspection have led to the conclusion that auditing and the governance processes implemented were not effectively applied. Oversight of the service from the provider had not adequately identified shortfalls and rectified matters in a timely way.

These concerns represented breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, for Good Governance.

Staff were positive about the change in ownership and the management within the home. One staff member said, "They are making things happen. There is more support. They are helpful and there are regular team meetings. I do not go home worried." Another staff member said, "Morale is much better now. Staff are beginning to help each other out now." The deputy manager was clear about the challenges faced and said that they were at the early stages of improvements. The key for her was to support staff through supervisions and boost morale. They also planned to work more at weekends to support the service and to be visible.

Management in the service were striving to create a positive and inclusive culture. They were seeking feedback of people using the service. A recent meeting had seen fifteen people attend. One person told us. "They do have meetings; I couldn't tell you what was said. I think we would be told if there were any changes." A relative told us. "At the relatives meeting they said they would get a communication book, but nobody seems to know about it." On the day of our visit we had to ask staff to refer a relative to a manager

and clear up a matter relating to communication. Also during our visit a communication book was placed in the reception area relating to environmental repairs. We were also told that a recent survey of people and their relatives was not available, therefore we conclude more is yet to be done to involve people, develop effective communication and for people to feel involved in the running of the service.

The service did work with other agencies and form partnerships. There was a good relationship with the local GP surgeries and the visiting nursing teams. There was a good working relationship with a specialist dementia team from the local authority who was visiting during our visit.

At the end of our inspection we fed back in detail our findings. We had established how many people were in the service and where they were. We had also established how many staff were supporting them. However, the two managers present had not got the information we held and were not clear how many staff were in the building supporting people. This lack of oversight on the day was of concern. We know from discussions after inspection that Anchor Trust have taken steps to further support this service. Additional managers have been put in place to support the service until a permanent manager is appointed and registered with CQC.

Anchor Trust had a regular programme of audits. That was capable of identifying shortfalls which needed to be addressed. Following the inspection visit we requested a copy be sent us of what they term an 'excellence tool'. We asked to see the action plans. This was a gathering together of different audits and management visits where any improvements were recorded and monitored and followed up. This document was not received. In relation to providing statistics on staff training there were gaps in the PIR and though requested information was not forthcoming following the inspection visit.

The providers' representative visited the home on a regular basis to check on the safety and quality of the service and to review any actions from previous visits. The previous registered manager had completed the PIR with details and gave evidence that we did not consistently find on our inspection 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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against risks relating to distressed behaviour due to dementia and potential falls.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems in place did not effectively address people's concerns raised nor were they used to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight, auditing and the governance processes were not effectively applied by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff to support people when needed.