Bupa Care Homes Limited

The Crest Care Home

Inspection report

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Date of inspection visit:
05 July 2017
06 July 2017

Date of publication:
01 September 2017

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected The Crest Care Home on 5 and 6 July 2017. The first day of the inspection was unannounced and we told the provider we would be visiting on day two. This was the first inspection of this service since registration with Bupa Care Homes Limited in January 2017. The service was previously registered under the Bupa brand.

The Crest Care Home is a large property which consists of a Victorian main building with modern extensions. The service can provide personal care for up to 31 older people. At the time of our visit 20 people lived at the Crest Care Home.

A registered manager was in post but was not at work at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that staff morale was low when we visited. Staff had not received appropriate induction, support and training to enable them to feel confident in their role. The staff team was made up of a small group of staff employed to work at the service and Bupa staff who worked elsewhere in the company, plus agency workers. Because these staff had not received the induction, support and training required they did not know people's needs as they should. This had led to a risk that people might not receive the support that had been agreed with them. This had also led to systems such as falls management, fire evacuation and medicines management not being robust enough to provide staff with the details on how to prevent avoidable harm.

We saw the provider had failed to ensure incidents they are required to inform the CQC about had been reported. This is being addressed outside of the inspection process.

Staff were aware of the signs of abuse and felt confident in how to report such concerns.

We saw the recruitment of staff and agency workers was not robust enough to ensure staff had good character and were suitable to work with vulnerable people before they commenced employment. The provider has assured us of the improvements made since the inspection visit. We saw the mealtime experience for people which included choice of food, environment and staff approach could be better. The area director explained the dining room was due to be moved to another area of the home to assist with this.

People and their relatives told us that they found staff caring and that staff treated them with respect. People told us overall they felt happy living at the service. People's nutrition and fluid intake (where needed) was monitored and we saw appropriate professionals had been involved if required.

People were offered choices and staff understood how to empower people to make such choices. This meant they were working within the principles of the Mental Capacity Act. Records to evidence this practice were being updated to make them more effective.

The inconsistency of staff was an issue. This had also impacted on the opportunities available for meaningful activities.

Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety.

People knew how to raise concerns and felt they received an inconsistent approach as to whether their day to day concerns were dealt with or not. Formal complaints had been dealt with appropriately.

The quality assurance systems in place had not highlighted all of the concerns outlined above and therefore were not effective enough to ensure a quality and safe service for people. The provider had responded to some of the issues prior to the inspection by deploying a registered manager from another service to oversee and provide leadership at The Crest Care Home, alongside support from their regional quality and support team. This had already impacted positively on recruitment and quality at the time of the inspection.

Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were found during this inspection. These related to safe care and treatment, person centred care, staffing, fit and proper persons employed and good governance. You can see what action we told the provider to take at the end of this 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?

Inadequate

The service was not safe.

Systems to manage medicines did not ensure people received their medicines as prescribed and in some cases we could not determine whether medicines had been administered due to gaps in records.

Staff had not had a thorough induction or handover of information about people and the risks involved when supporting them. This meant there was a risk staff did not know how to prevent avoidable harm occurring.

Staff had not received appropriate instruction on what to do in the event of a fire emergency. The provider explained they completed this immediately following the inspection.

The provider had not ensured safe recruitment checks had been completed before staff commenced working with vulnerable adults. Since the inspection they have confirmed this has now been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff felt unsupported because they did not receive appropriate levels of or effective induction, support, supervision and training from the manager and provider.

A refurbishment was underway including the re-location of the dining area which everyone felt would improve the mealtime experience for people. People felt the food overall was good.

People were supported to access healthcare professionals and services. Records on how to monitor when new healthcare appointments were needed were not robust.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their families felt that the staffing issues impacted on them receiving care from staff members who knew their needs and preferences.

People were supported by caring staff who respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of detail in care plans around how people preferred their support to be delivered. Also staff had not had opportunity to get to know people to enable them to respond to people's needs well.

People felt the opportunities available for them to access meaningful activities could be improved. The provider was recruiting an activities worker to support this improvement.

People knew how to complain and where formal complaints had been received we saw they were dealt with appropriately. Relatives felt day to day concerns were not always dealt with consistently.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager in post who was not available at the time of the inspection. A registered manager from another of the provider's services had been deployed to support the home as an interim measure.

Quality assurance systems in place had not effectively highlighted all of the issues we found at the inspection. This meant a quality and safe service was not being delivered to people who lived at the home.

Morale was low within the staff team and the provider had responded by asking regional support staff to help coach and support the team.

The Crest 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.

We inspected the service on 5 and 6 July 2017. This was an unannounced inspection on day one. We told the provider we would be visiting on day two. The inspection team consisted of two adult social care inspectors on day one alongside an expert by experience and a specialist advisor. The specialist advisor was a nurse who had expertise around medicines and risk management. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was prompted in part by the notification of an incident following which a person using the service sustained an injury. This incident is subject to an investigation and as a result we did not examine the circumstances of the incident during this inspection. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls. We examined those risks during this inspection.

We also considered the need to inspect the service following national concerns about the registered provider's services across the country.

Before the inspection we reviewed all of the information we held about the service. This included information we received from statutory notifications since the last inspection, concerns raised with us by relatives of people who used the service and feedback from the wider authorities such as the local authority, visiting professionals and NHS colleagues. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We also sought feedback from the commissioners of the service and Healthwatch prior to our visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return (PIR). This is a form that asks the

provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were 20 people who used the service. We spent time with four people and three of their family members. We spent time in the communal areas and observed how staff interacted with people and some people showed us their bedrooms.

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.

During the visit and following the visit we spoke with the supporting manager, regional director and seven members of staff including the deputy manager, two senior support workers, chef and care workers. The registered manager was not available during the inspection and the provider had arranged for a registered manager from another service to support The Crest Care Home. This manager is referred to as supporting manager throughout this report.

During the inspection we reviewed a range of records. This included eight people's care records, including care planning documentation, accident and incident records and medication records. We also looked at four staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

Inadequate

Is the service safe?

Our findings

We looked at the arrangements in place for the ordering, storage, disposal, recording and administration of medicines.

We saw the system in place was not robust enough to ensure people had received their medicines as prescribed. We saw some medicine administration records (MARs) did not have a photograph of the person. This meant staff administering medicines could not confirm the person's identity and prevent medicine being given to the wrong person.

We saw examples where staff had not signed the MARs which meant it could not be determined if people had received their medicines as prescribed.

Where people were prescribed topical medicines such as creams and lotions, protocols were not always evident to describe to staff where the cream should be administered on a person's body and for what symptoms. We saw administration of topical medicines was not always recorded.

Where people were prescribed 'as and when required' medicines, person centred protocols were not in place. Such protocols guide staff to understand the circumstances when people should be administered their medicine. Staff did not have robust details to help them make such decisions.

Where people required their health monitoring to help staff make decisions about when to administer 'as and when required' medicines, monitoring charts were not in place. For example; a person who was prone to constipation did not have their visits to the toilet recorded and therefore staff would not know when prescribed medicine to treat constipation was required.

We checked the storage and management of controlled drugs (CD's). CD's are medicines which require stricter legal controls to be applied to prevent them being misused, being obtained illegally or causing harm. We observed the key for the CD cabinet was left out on top of a storage unit in the treatment room; the keys should only be accessible by authorised personal to restrict access. We counted the stock of a sample of CD's and found this balanced correctly with records held.

We checked the temperature of fridges to ensure medicines required to be stored at specific temperatures were stored correctly. We saw the senior staff recorded the temperatures which were within range; however there were gaps in the recordings. This meant the temperature was not known on these dates.

We found no evidence that people had been harmed because of the above issues. However, all of the above demonstrates there was a risk that people may not have received medicines when required and as prescribed, or that medicines were not handled and stored safely. This was a breach of Regulation 12 :(Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and their families told us they felt they received good support in relation to their medicines. People

explained they received pain relief when they needed this. One person said, "I can ask a member of staff if I require medication."

We looked at four staff files and saw the staff recruitment process should have included completion of an application form, a formal interview, a full work history, references and a Disclosure and Barring Service check (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults.

We saw two staff files did not contain a full work history. Three staff files did not contain all of the references required. Two files did not contain evidence of a DBS check. We spoke with the supporting manager and they immediately requested the references not on file. The regional director has since confirmed that the records are now in place. From the information we received following the inspection we saw one staff member commenced employment on 22 May 2017 and their DBS check was not received until 18 July 2017.

Agency workers were supporting the service at the time we visited. Profiles containing information from the agency were in place; however they did not contain a photograph of the worker, confirmation of the DBS date or a list of dates when training had been completed. This meant the provider had no way of confirming their identity or suitability to carry out the role they were being asked to perform.

All of the issues identified with regards to recruitment meant the provider had not ensured thorough checks were completed to ensure members of staff were suitable to carry out their role and were of good character. This was a breach of Regulation 19: Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at the arrangements in place to ensure safe staffing levels. During our visit we saw the staff rota and the tool used to map the dependency of people who used the service, which was used to determine staffing levels were safe. We saw more staff were on shift than the tool stated was required.

The team of staff consisted of agency workers, members of staff from other BUPA services who had been asked to support The Crest Care Home and a small team employed to work at the service. We were told by the regional director that, over the past ten months, there had been a high turnover of staff. Recruitment of staff to replace those who had left had not been successful and this had led to the situation we found at inspection.

Although the numbers of staff were sufficient to meet people's needs, the deployment of those staff was not effective and there was little leadership around ensuring staff understood their roles and responsibilities and the needs of people who lived at the service. The deputy manager was new in post and the most experienced senior support worker employed by the service was due to leave on day one of the inspection. This meant the senior team was depleted and inexperienced. A care worker had been promoted from another service to be a senior support worker and needed coaching to enable them to perform their new role. This had already been arranged.

The impact of this meant one person had received breakfast at lunchtime, and that people did not receive consistent support because staff did not know their needs. A member of staff told us, "The impact on the residents is lack of continuity, people have not been neglected but it has caused them to be unsettled with all the new faces." A family member told us, "Part of the issue, there is not enough staff who know my family member well, there is only about three that really know her."

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

2014.

Following the inspection the regional director told us the supporting manager has started to recruit and more permanent staff were in the pipeline.

We looked at the arrangements in place to manage risk so people were protected and their freedom supported and respected. Risks to people's safety had been assessed by staff and records of these assessments had been reviewed. Risk assessments had been personalised to each individual and covered areas such as nutrition, pressure care and moving and handling. This enabled staff to have the guidance they needed to help people to remain safe. However, we saw members of staff, agency workers and staff deployed from other homes only knew information they had communicated to them, because they had not had time to read the care plan records.

We observed that some people living at the service displayed behaviours whereby they may refuse support. Staff told us they had not received training in how to intervene when a person required personal care but was refusing. We saw the care plan records did not provide staff with enough detail to help them feel confident around how to intervene. The result was that people had not received personal care support and this had led to one person who had dirty nails and clothing. We saw this was a concern brought up by relatives in the months prior to our inspection.

We listened to the staff handover meeting and looked at the records of previous handovers. We found information about risk was not sufficiently communicated either in the meeting or in records. This meant staff did not always know high risk factors such as people at risk of falls, people with specialist diets, the target amount of fluid expected to be taken and those people with epilepsy or diabetes. A member of staff told us this had led to them offering a person a piece of bread because they did not know the person's care plan stated they should not have this because of the risk of choking. A staff member stopped this happening before the person ate any bread.

We saw, for one person who had suffered falls, that no referral had been made to the falls team; the falls team can help staff understand how to prevent further falls. We saw that on one occasion a record about a person's fall had not been made where expected in the care plan so risk could be assessed when reviewed. This meant risk management was not always robust and did not involve professionals where needed. We saw the number of falls each month was audited to enable the provider to look for patterns and trends, although the figures recorded at this audit would depend on the correct information being communicated. As previously outlined records of falls were not always appropriately recorded.

We could find no records of induction of agency workers or staff deployed from other Bupa services. This meant they would not know safety protocols such as fire evacuation or people's preferences and care needs. When we looked at the fire evacuation records and fire training records it was clear not all staff had received appropriate instruction in the procedures to follow should the alarm sound.

All of this meant people were at risk of receiving care and support which would affect their wellbeing whether this is an act of omission or staff delivering incorrect care. Should an emergency have occurred such as a fire, staff would potentially not have known how to respond to keep people safe. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following day one of the inspection the supporting manager and regional director made plans to ensure fire evacuation practices and training was completed. They also placed each person's 'one page profile' which

contained details of their preferences and high risk factors on the back of people's wardrobe doors for staff to use as reference. The handover document was also adapted and we saw high risk factors for each person were recorded on a sheet for staff to use as a reference.

We saw records were kept relating to incidents and accidents. Some incidents were recognised as potential safeguarding concerns and had been referred to the local authority. The local authority had also received concerns from families and professionals which the manager had been made aware of previously. However the CQC had not been notified via statutory notification which the provider is required to do by law for incidents such as serious injury and incidences of abuse. We found nine incidences of potential abuse which we had not been notified of. We also found one incidence of serious injury we had not been notified of.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality commission (Registration) regulations 2009. This is being addressed outside the inspection process.

All the staff we spoke with said they would have no hesitation in reporting safeguarding concerns and they described the process to follow. They told us they had been trained to recognise and understand all types of abuse, and records we saw for regular staff confirmed this.

We looked at records which confirmed checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show relevant checks had been carried out on the fire alarm, fire extinguishers and gas safety.

We also saw personal emergency evacuation plans (PEEPs) were in place for each of the people who used the service. PEEPs provide staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. Tests of the fire alarm were undertaken to make sure it was in safe working order.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with during the inspection told us they felt they could be supported better. One member of staff described how they understood the induction for new staff had been completed by other new starters. They felt this had meant staff did not receive support and had subsequently left. Another member of staff described how they had been helping to induct a new staff member when they themselves were new to the home and from another Bupa service. We found these points had occurred.

We looked at records of staff supervision and saw staff had not received frequent and robust supervision from their line manager and appraisals had not been completed for most regular staff. One member of staff told us, "I do not feel supported" and another staff member said, "The new deputy is my line manager but I have not had supervision yet. I had one planned with the manager but they didn't do it. My last one was in 2016."

We spoke with people who used the service who told us they felt staff were well trained and could meet their needs. One person said, "From what I have seen they are well trained."

We saw the training matrix which outlined the training deemed essential by the provider. The matrix showed 85% of staff training was completed. This related to members of staff currently on the staff team at The Crest Care Home; it did not include members of staff from other Bupa services or workers from an agency. The supporting manager assured us the staff from other Bupa services had up to date training.

Agency profiles stated staff were up to date with training but they did not define what the training was or the date of completion. We could not find evidence that agency workers or staff from other Bupa services had received an induction.

Senior staff told us they had requested additional training to enable them to perform their role but the manager had not arranged this. The regional director explained that additional resources from the quality team had been deployed to support new senior staff via coaching. This was in its infancy and the staff themselves did not yet feel confident. We observed that care workers did not have the appropriate skill and knowledge to support people who displayed behaviours that may challenge the service.

Training, supervision, appraisal, induction and support are necessary to enable staff to carry out their duties. This was not effective and created a risk that staff were not suitably skilled or competent to fulfil their role. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood the practicalities around how to make 'best interest' decisions. For example offering choice, respecting people's decisions and involving people. We saw documentation was in place for people who lacked capacity where the service had assessed this was required. It was not always clear where a person had variable capacity which decisions they could make and where they required one to be made in their best interests. The supporting manager explained this was an area they would be developing with the team and senior staff to improve clarity.

Staff we spoke with had a good understanding of DoLS. The home was working with the local authority team to ensure applications were processed. At the time of the inspection one application had been authorised.

We saw the dining room was small and did not cater for the volume of people who could be accommodated at the service. We saw staff did not have access to seating when they supported a person one to one to eat their meal. This meant they stood over the person and this could be seen as intimidating or undignified. The regional director explained plans were in place to re-locate the dining room to another part of the house which would allow for more space. We saw consultation about this had happened with people and their relatives already. The regional director ensured fold away seating was arranged so staff could be seated whilst supporting people to eat their meal.

We received mixed views about the food from people and their relatives. One relative told us their family member had limited choice due to them not eating meat. People told us, "Yes, I like the food" and, "It's nice." Other people told us they felt the choice could be better. A group of people told us after lunch they had enjoyed their meal. One person said, "If we don't like the food they always give us something else. If we don't like it we tell them."

We saw options of the meals available were offered when meals were served. People who explained they did not want the options were offered alternatives from the kitchen. The food looked appetising although we saw the meat looked tough for people to cut on one of the inspection days. We saw one person struggling with this on day two of the inspection. Staff were attentive during meal service and responded quickly to assist people who maybe wanted more gravy or needed support to eat their meal.

We saw people's dietary preferences and needs were communicated with the kitchen staff and the chef knew who needed food prepared in different ways because of risk of choking.

We saw records to confirm people had visited or had received visits from healthcare professionals to help maintain their health. Prior to the inspection we had received feedback from a healthcare professional who felt a few people with more complex nursing needs were living at the service. We noted the service had liaised with professionals and each person had moved to more appropriate placements.

We discussed with the supporting manager how records relating to health professionals visits did not include the full history and some dates of appointments were lost because of archiving. For example, a person might only visit a dentist every two years and the last date could not be found. The supporting manager said they would seek to alter the records systems so this was clear and staff could see when appointments were next due.

Refurbishment had started in the service and the regional director explained how they were working to

improve safety by adding hand rails in corridors and also making the environment more dementia friendly so people could find their way to their room, lounge or other areas of the home.

Requires Improvement

Is the service caring?

Our findings

People we spoke with during the inspection told us they were happy and that the staff were caring. One person said, "They look after me too darn well if you ask me", another person told us, "They talk to me and we have conversations, they are so caring and they sit and listen to me" and "I am treated as normal - we get individual care." A relative said, "They [staff] always talk to her nicely and politely."

We asked people and their relatives if staff knew them well. Some people felt staff did and one relative told us, "I suppose staff know my family member well, they know I like them to look smart and nice." We observed the person was smartly dressed with colour co-ordinated clothes and they were pleased with their new shoes. Other relatives felt the inconsistent staffing meant not all staff knew their family members well. People commented that at times they felt staff did not explain things properly and one person told us, "I wouldn't say they know a lot about me, I feel we are more apart than pitching together."

We spent time observing staff and people who used the service. We saw staff interacting with people in a very caring and friendly way. We saw staff treated people with respect. Staff were patient with people and delivered support at a pace the person was comfortable with.

Observation of the staff showed some knew people very well and could anticipate their needs. For example, staff saw a person communicating they required support to use the toilet and quickly responded to help them. Staff who were new did not know people's needs as well. We saw staff were not confident interacting with people who displayed behaviours which may challenge the service. This had led to people not having their personal care needs met.

Staff were keen to build their skills and knowledge of people. Staff told us they cared for people's wellbeing and wanted to deliver the best service they could. They felt the staffing issues hampered this and impacted on their ability to get to know people better.

Staff told us how they worked in a way that protected people's privacy and dignity. For example, they told us about the importance of knocking on people's doors and asking permission to come in before opening the door. One person told us, "Nobody comes into my room without knocking" and "They always tell me who they are before coming into my room." This showed the staff team was committed to delivering a service that had compassion and respect for people.

We saw people had free movement around the service and could choose where to sit and spend their recreational time. The environment allowed people to spend time on their own if they wanted to. We saw people were able to go to their rooms at any time during the day to spend time on their own. This helped to ensure people received care and support in the way they wanted to.

During the inspection people showed us their bedrooms. They were personalised and relatives had supported people to bring their own items of furniture, ornaments and photographs.

Relatives told us they were involved in developing the care plans and making decisions about the family members care most of the time. One relative told us, "I know about the care plan and I sometimes get involved" and "Things do get discussed and they tell me about things."

At the time of the inspection one person who used the service required an advocate. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. Staff ensured they supported this person to spend time with their advocate when they visited.

Nobody at the time of this visit was receiving palliative care. Within peoples care plans we saw their preferences and wishes around end of life support were recorded for when this situation arose.

Requires Improvement

Is the service responsive?

Our findings

During our visit we reviewed the care records of eight people. We saw people's needs had been assessed and care plans had been written. We saw people and their relatives had been involved in developing the care plans. Basic information about people's preferences were included. For example, we saw in one person's care plan that they needed time to respond when asked a question to ensure they could express themselves. We saw people had a document in the care plan where their life history was recorded which gave staff information about the person's history and memories. A person was able to tell us that staff knew they liked a particular radio station and they would put it on for them to enjoy.

As outlined in the safe section of this report we saw members of staff, agency workers and staff deployed from other homes only knew information they had communicated to them, because they had not had time to read the care plan records.

Detailed information was not recorded about how staff should approach people to encourage and prompt them to be independent. There was also no record of how staff must respond when a person displayed anxiety and refused support. Staff appeared not to know how to respond to such needs, and this had led to people's needs not being met. For example, one person believed to be independent by staff, but who actually required support with personal care had not had their needs met. We saw care plans did not specify how to support people's continence during the night and we saw on day one that a person who staff felt was able to access the toilet had not received the support they needed when incontinent. One relative told us, "My family member's personal care could be better I am sure they sleep in their clothes." Staff we spoke with had no way of ensuring people they believed to be independent wore clean clothes or had their personal care supported.

Care plans did not contain the person centred detail on how people preferred their care to be delivered. Staff had not received the induction required to know people's needs and this meant people did not receive their care in a person centred way. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and their relatives explained to us that the activities worker had recently left. They were complimentary about the activities this worker had provided them with and spoke fondly of the worker who had left. They explained since that member of staff had left a replacement had not been found and people felt there was little on offer to support them to feel engaged and stimulated.

We saw that 'outside' activities were still available and people told us they enjoyed these activities. Examples were a singer and a person who did gentle armchair exercise with people. People said, "There was an hour of singing and dancing and telling jokes, I liked it" and "Staff do my nails and hair" and "Sometimes we have a film put on."

The regional director told us they had recruited but the candidate had chosen not to start in the role. They also explained they had asked staff to ensure activities were on offer each day in the afternoon. We did not

see this happening on day one of our visit and no records of such activities had been kept. Active recruitment to replace this role was happening. The supporting manager and regional director were both committed to ensuring people received good levels of activity in the future.

We looked at the complaints recorded since February 2017. We saw three had been received formally and we saw responses had been sent to the person raising concerns. People and their families told us they felt confident to raise concerns with the staff and manager.

One relative told us, "I know there is a form in reception." Some people said they had no cause to complain and one person told us, "I haven't had to complain." Other people and families felt that they received an inconsistent approach when they did raise concerns about day to day matters. One relative said, "I have mentioned a few things to staff, some sort it out and others don't. Communication is an issue."

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post when we inspected but was not available during the inspection. We asked people and their relatives what they felt about the leadership of the service. A relative told us, "There doesn't seem to be a settled management. In a place that specialises with dementia there should be continuity of staff. There is no substitute for experienced staff." People told us the manager was friendly when they saw them; one person said, "I like the new manager, he knows me, he always says hello."

The provider had a range of audits which they expected to be carried out by the manager to provide them with information about the quality and safety of the service. The audits had not been carried out consistently and were not robust because they had not identified the concerns we have identified in this inspection report.

The provider had completed audits of the service alongside those mentioned above and recognised leadership needed to improve. The regional director explained support from the provider's wider team to coach the new deputy and improve records relating to support and consent to care had already been organised and delivered prior to the inspection. However, the provider was not aware of some of the concerns we found such as the failure to report incidents to the CQC, which is being addressed outside of the inspection process.

This meant quality assurance systems were not effective enough to ensure people received a quality service which was safe. This was a breach of Regulation 17 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw two staff meetings had been held since February 2017; these had given staff the opportunity to raise concerns and discuss the service. The members of staff we spoke with felt the manager was approachable but that any issues they raised did not get acted upon. They gave one example where the manager had been shown a ceiling which looked unsafe; the manager did not respond and the ceiling subsequently collapsed. Fortunately no-one had been injured. Staff told us this made them feel like they had not been listened to. Staff told us the morale was low and that contributing factors were the staffing situation, lack of support and not being listened to.

We saw people and relatives had been invited to attend meetings to discuss the service and voice their opinion. Records of the meetings showed that people had been involved in the refurbishment and planning how to move the dining room. One relative said, "I have been to a few. The last one was this year sometime in February. I find them informative. Certain topics get discussed. Sometimes things get done. There is often a sign up saying, you asked for this and we did it." This meant people and their relatives had opportunities to discuss the service.

We saw that a survey had been conducted in 2017 to seek the views of people and their relatives. The regional director explained that too few responses were received to produce a meaningful report. They told us they were aware that, regionally, the themes requiring improvement were staffing, food and activities.

The regional director told us an action plan to improve would be produced as these themes were relevant to this service.

We asked people and their relatives what they felt the best things about The Crest Care Home were and they told us, "It is homely and not too big so people can find their way around" and "It's lovely to think there is always someone around to talk to. I have made some nice friends here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not contain full details on how to support people's needs and including their preferences. Staff had not read peoples care plans to direct them to deliver support how people preferred it. Regulation 9 (1) (3) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems to ensure people received their medicines safely as prescribed were not robust. Staff did not have full knowledge of the risks to people's wellbeing to enable them to prevent avoidable harm. This included a lack of knowledge and instruction of how to deal with emergency situations. Regulation 12 (1), (2) (a), (b), (c), (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective enough to ensure people received a quality service which was safe. Regulation 17 (1) (2), (a), (b), (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not safe because they did not ensure all checks to confirm a candidate was of suitable character to work with vulnerable people had been made before they commenced employment. Regulation 19 (1) (a) (b), (2) and (3) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff (including agency workers) had not received the training, induction, support and appraisal necessary to enable them to perform their role. Regulation 18 (1), (2) (a).