Norfolk Care Homes Ltd

Iceni House

Inspection report

Jack Boddy Way
Swaffham
Norfolk
PE37 7HJ

Tel: 01760720330
Website: www.zestcarehomes.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Iceni House provides accommodation and personal care for up to 74 older people, some of whom may be living with dementia. There were 67 people living in the home on the day of our inspection.

This inspection took place on 7 and 9 September and was unannounced on both days.

The previous registered manager had left the home in May 2016. A new manager had been appointed who had previously been working at the home as the deputy manager. They were in the process of completing a CQC registered manager's application. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection the home was rated good in each of the key questions is it 'safe', 'caring', 'responsive and well led. We rated the key question of 'effective' as requires improvement. However the home was rated good overall. At this inspection the home has been rated requires improvement in each of the key questions and overall. This means that there were more concerns at the home now than at the previous inspection.

The provider had a recruitment procedure in place; records did not however reflect that this was always followed when new staff were recruited. Staff were not always supported in their role through regular training and supervision.

There were insufficient numbers of staff on duty. Staff were not always deployed effectively in order that they could meet people's needs effectively.

Infection control monitoring within the home was in need of improvement. Staff did not always follow safe procedures to protect people from the risk of cross infection.

Staff had not always received the required training to enable them to meet people's needs. Staff were not familiar with the principles of the Mental Capacity Act 2005 (MCA).

People received support from staff that were mainly kind and caring. However, people were not always treated with dignity and respect because staff were task focussed and care took place in a manner that was not centred on them with hurried or little interaction.

There were systems in place for managing medicines in the home. A medicine procedure was available for staff and staff had completed training in relation to safe medicine administration. Medicines were stored safely and records showed they were administered as prescribed. Healthcare professionals such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

People were supported to maintain a healthy balanced diet. Dietary and nutritional specialists' advice was sought so that people with complex support needs with their eating and drinking were supported effectively. Records of support provided however did not always show that this care had been delivered.

We found the home was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were systems in place to protect people from the risk of abuse and harm.

There was insufficient staff on duty to meet people's needs. Staff were not effectively deployed and available at all times to meet people's care needs.

People received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective

Where people did not have the capacity to consent, the manager and staff had not always acted in accordance with the legislation and guidance.

People were supported to make choices in relation to their food and drink and to maintain good health.

People were encouraged to maintain a nutritious diet although the records in relation to people's fluid intake were not always fully completed.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some staff treated people in a kind and compassionate manner this was not always demonstrated by others.

People's care was not always planned and provided in a personalised, respectful manner.

Staff did not always have time to spend with people and were often task orientated.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive the care and treatment they needed at the times that they needed or wanted it.

Activities for some people were infrequent and there were limited opportunities to take part in any activities on some of the units.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality monitoring arrangements were not fully effective. They had not identified the concerns and shortfalls that we identified at this inspection.

There was insufficient oversight or monitoring which affected the quality of the support provided to people who required hydration and pressure care.

Iceni 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on the 7 and 9 September 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was a nurse by profession 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.

Prior to the inspection, we reviewed the information held by us about the service. This included previous inspection reports and notifications we had received. A notification is information about important events, which the service is required to tell us about by law.

We looked at the care of six people in detail to check they were receiving their care as planned. We also looked at records including three staff recruitment files, training records, staff duty rotas, meeting minutes, medication records and quality assurance records We spoke with eight people who live at the home, 11 members of care staff, four housekeeping staff, three unit managers, the manager and two of the company directors. We also spoke with relatives of three people currently living at the home.

Immediately after our visit, we sought and received feedback from three health and social care professionals who had regular contact with the service.

Requires Improvement

Is the service safe?

Our findings

Whilst people told us they felt safe at the service, a large proportion of the people we spoke with expressed their concerns about staffing levels. They and gave us examples where their needs were not being met in a timely way. For example, one person told us, "I feel safe here. The staff are very friendly and nice. If I press the call bell they generally turn up and help me, but there are not enough staff to when it gets busy." Another person said, "I feel safe here. However I have complained about the time it takes them to answer the call bell. It does not seem to be any better."

We spoke with people's relatives as part of our inspection. One relative said, "I think that they are short staffed and they also have a lot of bank staff who don't always know my [relative]." Another relative told us, "The staff are always busy, always rushing. In an ideal world there would be more staff. [Relative] needs two staff to help them, they often have to wait due to lack of staff."

Staff told us there were not enough of them to keep people safe and meet their needs. They told us several colleagues were either leaving or planning to leave their employment at the home in the next few weeks. We were also told that due to insufficient numbers of staff, they were not always able to get all people out of bed when they wanted to. Staff told us that they did not have enough time to spend with people and sit with them. Some staff we spoke with were concerned that they frequently had to ask people to wait for their support.

We were concerned about the impact that the reported lack of staff in some areas of the home was having on people. We carried out observations in all three units of the home on both days of our visit. During our observations we saw that staff support was centred on care tasks, with little opportunity to spend time with people. We observed that some staff were choosing to take their breaks together, leaving no staff available to support people during those times. The manager and unit leaders told us that they were aware of this and that staff had already been reminded that this was unacceptable practice however, we saw that this was still occurring. A relative told us, "The care could be better sometimes. My [relative] needs full time support but the staff don't have time to deal with my [relatives] individual needs. It's the little things they miss like leaving my [relative] lying flat and risking them choking."

During our visit we observed one person going into another person's room whilst that person was still in bed. There were no staff in the vicinity, so we intervened and found a staff member to assist as the person shut the door and was in the room alone with the other person. One relative we spoke to described a similar situation saying, "My [relative] feels generally safe here. [Relative] does worry about the people who have dementia as they can wander in to their room at any time."

We spoke with the manager and the directors about the concerns raised with us about staffing levels. They told us they used a staffing tool to assess the dependency needs of each person and to determine the number of staff required and told us they felt sufficient staff were in place. They described how they were asking some staff to move to different parts of the home to work where some units were busier than others.

We found that there was an insufficient number of staff deployed and available and this impacted on the care and safety of people living at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by robust recruitment procedures. From the five staff recruitment files we viewed, three were missing information or did not have the appropriate pre-employment checks completed. Staff being employed to work in care settings must have a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff have a criminal record or are barred from working with adults. One staff member's DBS check had showed they had received a number of police cautions. We saw, however, there was no evidence of the manager or directors reviewing these concerns with the staff member or considering any potential risks involved in employing them. We saw in the other two staff files that one person had not had gaps in their employment history explored with them. The third staff file we looked at had a reference held on it. However the reference was a record of a telephone conversation with the previous employer where the staff member's employment was confirmed but no further details provided. There was no record of this information being verified to prove authenticity. The provider was not able to demonstrate how they ensured staff were suitable to support the people in the service. This was leaving people at risk of harm because the provider had not taken all the appropriate checks to ensure staff were suitable for their role. Following our visit the director of the company provided us with information about action taken with regards to recruitment of staff, but which had not been recorded within the records.

We saw that most concerns that had been raised with the management team in the home about possible alleged abuse had been reported to the relevant authorities for investigation. We saw two incidents which had occurred between people that had been recorded in their care notes however no incident form had been completed. We spoke to the manager about this during our inspection who agreed to follow this up immediately. Most of the staff we spoke with knew how to protect people from the risk of harm and abuse. They understood the different types of abuse that could occur and were clear that they needed to report any concerns they had to their manager. However, most staff were not aware of whom to contact outside of the home if they felt they needed to escalate their concerns. Following our visit the director shared with us information and about safeguarding and how this was shared with staff. However on the day of our visit most staff were not able to tell us about the process of raising safeguarding concerns externally of the home.

There were systems in place to reduce the risk of people being harmed. Potential risks to people had been identified and subsequent risk assessments had been completed. We saw risk assessments were carried out in areas such as falls and the risk of choking. We saw that in both these areas; follow up referrals and appointments with health professionals had been arranged to help keep people safe.

Where appropriate care plans were in place to reduce any risk such as providing pressure relieving equipment for people who had a high risk of developing pressure ulcers. Nutritional risk assessments were in place and action taken if a person had weight loss or became unwell. We saw, however that these risks were not monitored with effective record keeping. We discussed this with a unit manager who took action to address this on the day of our inspection.

Systems were in place to ensure people received their medicines safely. Medicines management was good and daily audits took place to ensure that people received their medication as prescribed. Staff who administered people's medicines received appropriate training and their competency to do this was regularly checked. We found that people's medicines were stored securely. During our visit the records of medicines storage temperatures could not be located however the area was air conditioned and was at the correct temperature when we checked. We asked people whether they received their medicines at the right times and when they needed them. One person said, "I always get my medication on time and they [care

staff] stay and make sure that I take it."

Infection control practice was observed to be poor in some areas of the home. On one unit we found there was a strong smell of urine. The manager told us that the flooring and under floor had already recently been replaced in this area; however the odour was still present. We observed one staff member wearing the same disposable gloves during contact with two people, having left one person's bedroom wearing the gloves and going to support another person straight away. We also were concerned that appropriate methods were not always used to transport soiled linen as we observed care staff held soiled linen/clothes against their uniforms when carrying through the unit. When we spoke with the home manager about this they told us that they had also observed this at the same time that we did and would be addressing it with care staff.

During our time on one unit we saw that at 12 noon there were the remains of people's breakfast still on the tables, on plates which had been left out and a lot of food crumbs on the floor. These were attracting flies within the dining area. Despite both care staff and housekeeping staff entering this area a number of times whilst we were in there, no one attempted to clean this up. This did not promote good food safety and hygiene in this area.

The manager and one member of staff told us that care staff were not permitted to wear nail varnish or have long fingernails for infection control and safety reasons. Despite this we observed six staff either wore nail varnish or had long fingernails This placed people at risk of the spread of infection. The home manager told us they had been working on a local authority Infection Prevention and Control Action Plan and all actions, with the exception of one, had been met. However, we saw that there had not been a proactive approach to promoting this within the service.

Requires Improvement

Is the service effective?

Our findings

The MCA provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be made in their best interests and be the 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 for these procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection during February 2015 we were concerned that the provider was not meeting the requirements of the DoLS. Appropriate applications to the authorising body had not been made. We found at this inspection that the manager had submitted DoLS for people who they considered were being deprived of their liberty.

The staff and manager told us that there were people who lived at the service who lacked capacity to make decisions about their care. This means staff had to work within the principles of the Mental Capacity Act 2005 (MCA). We found that some staff had received training in, and had a basic understanding of MCA and DoLS. However not all of the staff we spoke with had heard of the MCA and DoLS or what it meant in practice at the service. Despite not having the knowledge of the legislation we saw from our observations that staff were seeking people's consent before performing a task with them. One person we spoke with told us, "They always ask before they enter the room and speak very nicely to me." A relative said, "They are always very kind and always ask before they do anything."

At the time of our visit we found that DoLS applications had been made to the local authority in relation to people who lived at Iceni House and these were awaiting an outcome. We could see that whilst they were awaiting authorisation, the least restrictive methods within their best interests were employed to keep people safe.

We found that capacity assessments for specific decisions such as whether a person could consent to use bed rails were not detailed. There was no evidence to show how the people whose records we viewed had been supported to consent to or understand the decision to be made. After our visit one of the directors told us that whilst the forms in use did not make it prominent that a best interests decision was carried out, they were undertaken where a person lacked capacity.

People and their relatives that we spoke with told us that they felt the staff supporting them had the skills necessary to provide effective care. One person said, "The staff know what they are doing and if they don't then they make sure they find out." Another person said, "The [care staff] know what they are doing and do it

very well." A relative told us, "They [care staff] are very supportive of my [relative] and know exactly how to care for them."

People were supported by staff that were trained and experienced to provide their care however staff were mixed in their views about whether the training met their learning needs and provided them with the skills and knowledge they needed to do their job. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. We spoke to 11 staff about the training they had received.

Staff were mixed in their views about the effectiveness of the training with most stating that they did not find the online training useful. One member of staff said, "I don't think the training is adequate. It's all e-learning and not practical training. I have not had any training in dementia, only a few staff have." Another member of staff said, "We mainly have e-learning for training which is okay. We recently had someone come and do dementia training which was really good. More of that would really help us to look after people better." Other staff were complementary about the learning opportunities they had. One said, "Dementia training was the best course I've done. It was very good and made me see people who have dementia in a different way, it enlightened me."

At our inspection in February 2015 we recommended that the provider consider guidance about staff supervision to ensure that staff were adequately supported in their role. Staff we spoke with at this inspection told us they had regular supervision but did not feel appropriately supported by managers. One member of staff said, "I have supervision, I can speak up but nothing happens and nothing changes." Another member of staff said, "More support would be good. If I was the manager I would give the staff more praise for the good work they do." Records we looked at showed staff received regular supervision. The aim of supervision is to provide staff the opportunity to review their performance and training and discuss development requirements with their line manager.

We asked people using the service about the quality of food they received at the home. They told us that the food was good, and that there was always a choice. One person said, "The food is very good here and I always get what I want and however much I want. I have porridge for breakfast for the weekdays and always have a fried breakfast at the weekends." Another commented that meals were often large and plentiful and said, "The food is quite good and there is always more if you want it."

We observed the dining experience that people received on two of the units. We saw on one unit that people were waiting at the table for at least thirty minutes before their lunch was served. We were told after our visit that this had been an extraordinary delay due to an issue within the kitchen. There were no condiments on the tables and people had paper towels to use as napkins. When the food was served we saw that people were offered a choice of two options. Staff working on the unit told us that people could have an alternative if they did not want what was on offer and that the chef would always prepare an alternative. We saw that one person had a very large dinner and dessert served by staff. When we checked their care records it was documented that the person liked large portions of food.

People that we saw being supported by staff to eat were treated with dignity and respect. The staff members told them what was on the fork before offering it to them and conversed with them whilst they were having their meal.

We looked at people's care records to check how they were cared for in relation to eating and drinking. One person's file stated that they needed to have their fluid intake monitored due to them not drinking enough. We also saw that other people were assessed as being at high risk of dehydration. On one unit we saw that

people's fluid intake was monitored over a 24 hour period however the amount of fluid they were consuming was not totalled up at the end of the day. We also viewed five further fluid chart records and found that the records were incomplete. On another unit we viewed two further people's fluid records and saw that their daily fluid targets were not met. Staff we spoke with about this told us that on one of the days we identified staff were not able to offer more fluids to people due to being too busy with other people's meals We spoke with one of the senior care staff who was aware that there was national guidance available in respect of monitoring fluid in intake and before we left the premises they had updated the records.

During our observations we saw that people had access to drinks when they were in their own rooms or in a communal lounge. We also saw that records of food people had eaten, where they were at risk of losing weight, were completed. In addition nutritional assessment tools used by staff were in place and had been updated regularly. This meant that staff were supporting people with their nutritional intake and monitoring this for any concerns.

A person we spoke with told us about their access to healthcare support saying, "They arrange all GP appointments and I can get a dentists appointment and a chiropodist visit to do my feet." Another person told us, "I can always get to see the doctor whenever I want." People's care plans included a record of all visits that people had made to healthcare professionals, and their outcomes. People were able to access the appropriate healthcare support such as the dietician, GP and community nurse to meet their on-going health support needs. We saw records that demonstrated that appropriate referrals had been made when people required on going support with their dementia diagnosis. One healthcare professional we contacted as part of our inspection planning told us they found the manager and unit leaders skilled and professional in making requests for support and following up recommendations made.

We found that the physical environment throughout the home did not reflect best practice in dementia care and wasn't in line with current published guidance. During the inspection we spent time in a unit of the home where people who were living with dementia were accommodated. We found that there were very few objects of stimulation or distraction in the unit. The décor was very nondescript with limited pictorial or colour used to create an interesting and stimulating environment for people. There was no further evidence of adaptations to the environment to show good practice guidelines had been put into practice. We asked the registered manager what model of dementia care the registered providers adopted. She confirmed that some research had gone into the environment following research on the internet and confirmed that further work would be undertaken to develop this area.

We recommend that the provider refers to current guidance about adapting the environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

We asked people using the service about their experience of the care and support they received. Their responses were mostly positive. One person said, "Yes, they are very caring and nothing is too much trouble." Another person told us, "The staff are caring and will help if you ask. They are very polite and will ask if they can come into the room before coming in." However we also received comments and feedback from people such as, "It is nothing special here. Some of the staff are not very polite to me." As well as, "On the whole the care is okay. They do their jobs but have little time to talk as they don't have enough staff."

Despite some people telling us that they were treated with dignity and respect, we observed that some staff failed to fully show consideration for people. In particular we noticed that some staff did not always fully communicate with those people with reduced mental capacity. This varied between different units at the home. On one occasion we saw a member of staff promising on several occasions to support a person with a task they wanted to complete. Despite telling the person on numerous occasions they would help them, another staff member approached them 45 minutes later in a communal corridor and told them that no staff would be helping with the task today, the staff member told the person, "She [the staff who had promised to help the person] has got to toilet a person so she won't be taking you out. It's not our [staff] fault there are not enough of us." This caused the person to become distressed, at which point a senior carer approached them and spent some time with them to establish what the cause of their upset was.

Some staff did not always knock on people's bedroom doors. We saw this during our observations and also experienced this when we were talking to a person in their room and a staff member opened their closed door without knocking and walked in. This meant that people were not necessarily afforded the level of privacy that they may have wanted or given the opportunity to refuse entry to their room.

Staff we spoke with confirmed that they knew how to respect people's privacy however. We were told, "I always make sure I help people in private. I close their curtains and their door."
All the people we spoke with told us they could have visitors whenever they wished. The relatives we spoke with told us they could visit at any time and were always made welcome.

At other times during our inspection, we observed interaction between staff and people who used the service and it was kind and caring. We saw examples where care staff were supporting a person to move and they provided caring reassurance and gentle communication throughout. We saw other people being offered a choice of where they wished to sit and staff checking if they were okay and comfortable. On one occasion a person was distressed because they couldn't find their bedroom. A staff member approached them and gently reassured them and said, "Don't worry, we can find it together."

One relative we spoke with stated, "The care here is getting much better. The new manager is trying to get a grip of it and I think she will bring the place up again. On the whole I think the carers really do care. "

Staff we spoke with were positive about the people they supported with one saying, "I love the people here like they were my own grandparents." Another staff member said, "I love my job with the people who live

here. There are things for us to improve on but some things are done well too."

We saw from the care plans we viewed that people and their relatives were involved in the initial assessment of their care needs. We also saw that reviews of people's care had taken place and that people relatives were contacted to see if they were able to attend a formal review of care.

Requires Improvement

Is the service responsive?

Our findings

People, relatives and staff told us that in their opinion there were insufficient staff to provide for people's needs effectively. The central concern of people that we spoke with, their relatives and staff related to the staffing pressures at Iceni House. The general feeling was that there were not enough staff to support people. One person said, "I have complained about the time it takes for carers to respond to the call bell. It does not seem to be any better."

A relative of a person said, "Staff are always busy, always rushing. They need more staff. My [relative] needs two staff to help them which means they have to wait a long time due to a lack of staff." Another relative told us, "You buzz for help and nobody appears and you have to go and find them. My [relative] felt sick one lunchtime and so I took them out of the dining room, but nobody came to check how [relative] was or if I needed any help."

People were complimentary about some individual staff but said there were 'simply not enough of them.' They told us that they had to wait for staff to respond to their call bells. One person told us, "They will come when I press the buzzer, but sometimes they can take a long time. It would be useful if they let you know they are busy and will be there soon." A second person said, "They don't always respond well to the call bells. When I rang the call bell because I needed the toilet the staff came and said the bell is only for emergencies and I would have to wait for them to come round. They need more staff." We asked staff about their response time to call bells. Staff told us there were not enough of them to answer peoples call bells in a timely manner and meet their needs.

We observed and heard a number of people's call bells sounding throughout the two days of our inspection. During our observations, we found that staff were often responding to the call bells; however they were doing so just to tell people that they would be back to them when they had the time.

Staff also told us that due to the levels of staffing they were not always able to get all people up when they were awake or when they wanted to get up. They also told us that they did not have time to sit and spend with people. Some staff we spoke with were concerned that they frequently had to ask people to wait for their support. They told us they this meant they had to rush to complete all tasks required. Staff told us that on some days they were not able to offer people adequate fluid as they were too busy with other tasks.

We asked the manager about whether they monitored the length of time it took staff to answer people's call bells however we were told there was no ongoing monitoring undertaken. Following our visit, however, the manager told us that they had begun implementing a call bell audit and had already addressed concerns and were making improvements necessary.

We noted one person was prone to the development of pressure ulcers. They had a plan of care in place which stated they should be turned every two to four hours. We saw however that the records of care that had been recorded by care staff indicated that the person had been left lying on their back for longer than the recommend time. We asked staff about this, one told us, "People don't get proper care. We are rushing

around trying to do everything."

Each person had a personalised plan of care which provided information about their support needs. Care plans contained information about people's care needs and the actions required in order to provide safe and effective care. We saw however that people's personal preferences were not always included, for example there was no information in the care plans about peoples bathing preferences or their preferred times of getting up in the morning or going to bed. We spoke to staff about their knowledge of people's preferences. Several staff told us that they helped people up and with their personal care in the mornings according to where their bedroom was. One staff member also told us that night staff routinely helped some people up early in the morning to save the day staff time.

We spoke to the manager and one of the unit leaders of the home about the lack of personalised care at the home. They told us that they were working to change the culture of the team and the home through increasing the person centred care staff deliver. Person centred care is a way of helping someone to plan their life and support, focusing on what's important to the person. Staff we spoke with told us that they did not have the time to focus on person centred care. One staff member said, "This home advocates person centred care to us but we can't give it. We are too short staffed." Another staff member said, "We can't give person centred care here, we can't give people what they want, there are too many staff leaving every month."

We asked people how they spent their time. People told us there were limited things for them to do at the home. Comments from people and relatives included, "I would like to be able to get out more but there is nobody to help me because they are so busy. More staff would help. I can't get to the day room without someone coming to wheel me along. Nobody really talks to me about what I need and make it happen." Another person said, "There is not enough activity here." A third person told us, "A lot of people just sit in their room and do nothing." A relative we spoke with told us, "They don't do a lot of activities which are suitable for my [relative] so they just sit there."

Staff we spoke with confirmed there were limited activities at the home and more needed to be done to stimulate people. One member of staff told us, "People are bored, they're not happy." Staff told us about the arrangements for activities within the home. The home employed activities staff to undertake activities with people. On the ground floor, the unit was supporting people who were living with dementia. It was on this floor that the activities room was situated and we were told the activities staff based themselves. Staff told us that people who were living upstairs at the home often refused to go downstairs to attend any activities which were taking part or were not offered to join in.

We spoke with the manager about the activities on offer for people. They had already recognised that improvements were needed and told us that plans had been agreed to convert one of the communal rooms upstairs into an activities room. They told us that this would mean that people living on the first floor of the home would be able to access activities without going down to the unit on the ground floor.

We concluded that there was a lack of person centred care, and this was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the homes complaints records. This showed that procedures were in place and could be followed if complaints were made. There was a policy that provided people who lived at the home and their relatives with information about how to raise any concerns and the process that would be followed. The relatives we spoke with were aware of the complaints process. One relative told us they had used the complaints procedure with good effect. They said, "I had cause to complain several times a few weeks ago. I

complained about the standard of care my [relative] was getting. I want to make it clear however that when I did so the unit leader escalated my concern to the manager and they were both immediately proactive, really good and things have improved."

Requires Improvement

Is the service well-led?

Our findings

At the time of our visit, there was no registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The previous registered manager had left the home in May 2016. The current manager had submitted an application to register with the Care Quality Commission. They had previously worked in the home as the deputy manager and had recently been promoted.

At our last inspection during February 2015 we rated the home as good in four of our key questions and requires improvement in one. This meant that we rated the home 'good' overall. At this inspection we have rated it as 'requires improvement' in all five key questions and overall. This means that we considered that there were more concerns at the home now than when we last inspected it. We found that the home was going through a period of significant change. As well as a recent change of manager there had also been a change in function of the home when the directors took the decision to remove the nursing element of the registration of the home. From talking to people, their relatives and staff as well as our observations we recognised that the manager and directors had a number of challenges at the home which they were trying to address.

Although there were systems in place to assess and monitor the way the service was run, we found that they had not identified or fully addressed all of the issues that we found during our visit.
Whilst staff were aware that some people were at risk of dehydration and pressure ulcers, we identified that the corresponding records and charts were not always completed. It was not clear who checked the total fluid intake or repositioning charts were completed. The wellbeing of those people who required this support was dependent on staff to ensure they received adequate nutrition, hydration and pressure care. Staff recruitment records were not always up to date with information not always recorded in them to reflect discussions held during interviews. Accurate record keeping was an important part of these processes that was not always well managed.

The manager told us that there was not an annual review carried out at the service. Instead the home had a supply of generalised feedback forms from an online website. We were told that relatives were encouraged to complete one of these to provide their comments on the home, the outcomes of which would be displayed on a website. This meant that there was no formal way in which the home was seeking people's opinions on the home and analysing them in order to review the service and plan for the future. The manager told us that they had plans to introduce a more detailed system where people and their relative's opinions would be sought.

Following our visits, one of the directors of the company told us that six monthly formal meetings with service users and families were held. We were told that these were attended by the home manager and directors and the purpose of them was to obtain feedback on the service people were receiving.

Staff we spoke with were mixed in their views about the management of the home. Some staff were very unhappy about recent changes made and this reflected in their comments to us about the manager and directors.

We concluded that there was a lack of management oversight and effective management of change at the home, and this was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home manager to be open and transparent about the challenges they were facing since being recruited as home manager. They had introduced a 'heads of meeting' within the service so the unit managers and other members of the management team could increase communication and review the management of the service. We were concerned about the management oversight of the units; despite being previously instructed to take their breaks separately, staff on some units were still undertaking this practice. This left people with no staff to support them during this time. Unit managers had not addressed this practice effectively at the time of our inspection. The manager and unit managers told us they were continuing to address this with staff.

The relatives we spoke with were complimentary about the manager, describing her as approachable and they told us that she had a visible presence within the home. One relative said, "The manager seems really proactive and not afraid to say what she thinks. Oh the whole I think there are improvements and under the current manager the home will come to the right standards again." Staff members we spoke with described a feeling of low morale at the home. We were told that there had recently been some changes to working practices at the home and staff had recently been asked to work on other units to the one they ordinarily worked on. They told us that they felt this was unfair. In addition, some staff spoken with felt dissatisfied with the arrangements for training and support in preparation for working on other units within the home. The manager and directors told us that whilst they recognised that the changes were difficult for some staff, support and training had been made available. In essence, the managers and directors told us that they needed to deploy care staff where people had the higher support needs in order to best use resources and meet people's needs. .

Meetings were held for the staff team, so that any important information could be disseminated throughout the workforce. This enabled those who worked at the home to discuss any relevant topics and to keep up to date with any specific changes. We saw that in one of these meetings staffing levels were discussed and how there were plans for staff to work across the home. We also saw that staff were reminded of the importance of participating in activities and spending one to one time with people. One of the unit managers we spoke with told us the management team at the home had spent considerable time working through the staff rotas deciding on who would work on different units to make it fair to all staff.

Other internal audits were in place and used to identify trends in care provision, for example in the number of people falling at the home and other incidents and accidents. The manager had introduced a system where she used a plan of the home to identify where people may have failed to look for any patterns or concerns. Others included audits of people's care plans and medicines. The manager told us that one of the directors visited the home every week and that they were supportive. We saw however that no formal audits of the service to look at the quality of care being provided were carried out by the directors.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). We checked the records at the service and we found that incidents had been recorded and reported correctly

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 Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-Centred Care There was a lack of person centered care for people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance. The provider was not operating effective systems and processes to assess and monitor their service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing There were insufficient staff appropriately deployed to support people in a person centred and responsive manner.