Huntercombe Centre (Crewe) Limited

The Berkshire Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17, 19, 23, 25 February and 01 March 2016 and was unannounced. We last inspected the service in January 2014. At that inspection we found the service was compliant with all the essential standards we inspected.

The Berkshire Care Home is a care home with nursing that provides a service for up to 58 older people, some of whom may be living with dementia. The accommodation is arranged over two floors. At the time of our inspection there were 46 people living at the service.

The service did not have a registered manager as required. However, the home manager was in the process of applying to the Care Quality Commission (CQC). 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.

Changes to people's care and treatment needs were not always well recorded. In some cases this put people at risk. They were not having their individual health and care needs met on time. People had sufficient to eat and drink to meet their nutrition and hydration needs, however support from staff at meal times was inconsistent. People had access to health care professionals. However, staff did not always record and act upon health issues. Therefore, appropriate care and treatment was delayed and did not help people stay healthy at all times.

People's safety was compromised in the home. The premises and some equipment were not cleaned or well maintained. Procedures to control the spread of infection were not robust. There was inconsistent and ineffective support for people who became distressed or who were unable to make their needs known.

We observed kind and friendly interactions with staff. People and relatives made positive comments about the staff and the care they provided. However, we observed people's dignity was not always respected and their privacy was not always maintained. There was an activities programme, however opportunities for social engagement were limited and some people living at the home were not engaged in meaningful activities to avoid isolation.

The provider had a system to assess staffing levels and make changes when people's needs changed. The provider was using agency staff to ensure the right numbers during each shift and was trying to book the same agency staff to maintain continuity of care and support. People told us they thought the changes in staffing could affect some of their support as the new staff did not know them well. We saw the time to answer calls bells varied. Relatives told us there were not always enough staff to support people with activities.

Staff training records indicated which training was considered mandatory by the provider. Not all staff were

up to date with, or had received their mandatory training. We saw evidence that learning was not always put into practice when staff supported people. The provider could not be sure staff had the appropriate knowledge and qualifications to meet people's needs at all times. Staff said they felt supported to do their job and could ask for help when needed. However, they did not receive regular supervision. The team meetings were not always held regularly, thus opportunities to discuss matters with the team were not always available. We asked to see evidence regarding staff's professional development such as National Vocational Qualifications (NVQ) or Qualifications and Credit Framework (QCF) awards. However, we did not receive any information regarding this.

Relatives felt their family members were kept safe but were not always satisfied with the care and support provided. Care staff knew how to identify potential abuse and understood their reporting responsibilities in line with the service's safeguarding policy. Staff followed the principles of the Mental Capacity Act 2005 (MCA) when supporting people who lacked capacity to make decisions. We reviewed information held regarding Deprivation of Liberty Safeguards (DoLS) to ensure people's liberty was not restricted in an unlawful way and people's rights and freedom were protected. Although the provider had taken some action with the local authority to apply for DoLS we did not receive sufficient information regarding all the people living in the home to ensure appropriate measures were in place.

The provider had systems in place to assess and monitor the quality of care. The provider investigated and responded to people's complaints, according to the provider's complaints procedure. Annual questionnaires were sent so people and relatives could share their views. However, the quality monitoring system did not effectively identify all issues, practices or concerns with the home. Without an effective system the home was not able to make improvements where and when necessary so that people could receive the support and care they needed. There was a reasonable amount of resources provided to address the issues and concerns raised by us and other professionals. However, we did not see a steady progress of addressing these. We were concerned that the lack of organisation and leadership prevented improvements being achieved promptly. The provider did not take proper steps to ensure people were protected against the risks of receiving unsafe and inappropriate care and treatment.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of 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 always safe. There were enough staff on duty. However, the organisation of the staff did not allow them to spend time engaging with people and meet all people's needs.

People were at risk because premises and equipment were not managed well to keep people safe. Cleanliness and hygiene standards had not been maintained at all times to prevent cross infection and illnesses. Medicines management was not always safe.

Staff knew how to identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused. The provider's recruitment processes were robust.

Is the service effective?

Inadequate

The service was not always effective. People's needs were not always met because staff did not always follow the care plans. The provider did not keep accurate records or take swift action when people's health deteriorated.

Staff did not receive regular supervision but felt they were supported to carry out their jobs. They did not always receive the required training that would enable them to meet people's needs effectively. Staff did not always have the knowledge they needed to support people in stressful situations.

Although some DoLS applications were made to local authority, we did not receive sufficient information to ensure people were deprived of their liberty in a lawful way.

Staff promoted people's rights to consent to their care and their rights to make their own decisions. Staff were aware of their responsibilities to ensure people's rights to make their own decisions were promoted.

People had sufficient to eat and drink but they gave us mixed comments about the home's food and mealtime experience.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always supported with care, respect and dignity. Most relatives and people were positive about the staff and the care they received. However, this view was not always supported by our observations.

Visitors were welcomed and people were able to maintain relationships important to them. People, and those that mattered to them, could make their views known about care and treatment however concerns were not always addressed in a timely manner.

Is the service responsive?

Requires Improvement

The staff were not always responsive to people's needs. People's individual needs were not supported at all times. Care plans did not always show the most up-to-date and important information on people's needs, care and welfare. Staff did not always interact with people or respond appropriately to people if they needed help or support.

There was an activities program. However, there were not enough meaningful activities for people to participate in as groups or individuals to meet their social needs. The service managed complaints that had been raised.

Is the service well-led?

Inadequate

The home was not well led. People were put at risk because systems for monitoring the quality of the service and risks were not effective.

The provider did not organise and lead the service successfully so that concerns were addressed swiftly. Monthly audits were not carried out on a regular basis.

Problems with the service and required improvements were not always identified and this had an impact on people. We did not always see evidence of action plans or action taken where concerns had been highlighted.

The home management team was available to people, relatives and staff and they had opportunities to discuss various topics and raise concerns.

The Berkshire 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17, 19, 23, 25 February and 01 March 2016 and was unannounced.

Over the five days, the inspection team consisted of the lead inspector, two other inspectors, inspection manager and specialist advisor.

We carried out this inspection due to a number of concerns raised. We also looked at all the information we had collected about the service. This included previous inspection reports, information received from health and social care professionals and information from others with a connection to the service. We also looked at notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During the inspection we spoke with 15 people who use the service and 4 relatives. We spoke with six care assistants, three registered nurses, five agency staff, activity coordinator, domestic staff, administration staff, the home manager, two clinical facilitators, clinical manager, the regional manager, and the director of operations. We observed interactions between people who use the service and staff during the five days of our inspection. We spent time observing lunch in the dining room. We received feedback from external professionals. We looked at 12 people's care plans, 13 other care documents, medicine records, six staff recruitment files, staff training records and the staff training log. Medicines administration, storage and handling were checked. We reviewed a number of documents relating to the management of the service. For example, various audits, meeting minutes, activities plan, residents and relatives survey from 2015, incidents and accidents log, complaints log, service maintenance and daily walk around records.

Inadequate

Is the service safe?

Our findings

People felt they were safe living at the home. Staff had a good understanding of safeguarding and told us how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. Staff knew when and who to report any concerns or abuse to. Some staff felt people were safer now because the concerns raised were being addressed and changes were happening at the home. We were aware at the time of our inspection there were a significant number of safeguarding investigations on going. The provider was working together with the local safeguarding team to investigate and address these.

Risks to people's personal safety had been assessed and some plans were in place to minimise these risks. However, some risk assessments did not identify what measures should be followed to ensure people remained safe. For example, we reviewed a moving and handling risk assessment. The assessment indicated how the person wished to be transferred and the support they would like to receive. However, nothing was written to ensure their safety was maintained while transferring so injuries were not sustained. We also observed a person being hoisted from their wheelchair to a chair. Although the staff were very gentle and helpful, reassuring the person throughout, they did not follow the process correctly. The person was released from the hoist before they were correctly positioned into the chair. The staff did not use the guided knee technique to allow the person's hips to be correctly located as far back in the chair as possible. Therefore once the hoist was removed, the person had to be manually repositioned as they were at risk of slipping out of the chair. Pillows were also used to gain a safe sitting position for the person in the chair. We could not be sure that moving and handling practices were always safe.

Risk assessments were also carried out to determine the support people required in repositioning and turning to ensure their skin remained intact. During our inspection we observed a number of people, we noted when they should have been turned, how often and what records were kept. Some people got up later in the day. However, some people remained in bed all day and did not appear to be turned at the required intervals. For example, we visited a lady who was asleep on her back five times throughout the day. She remained on her back throughout our checks. However, the records indicated she was moved onto her left side. The only time we saw she had changed her position slightly was when she was sitting up for her meal. Another gentleman had to be turned every four hours. Every time we visited he was on his back although the records stated he was on his left or right side. The staff explained they were using a pillow to move him onto different sides. However, we saw the pillow did not make the person turn to the left or right side. We also noted the records were not filled in after the support was provided. Staff were recording or amending records kept in the room retrospectively, suggesting evidence of people not being turned as the records indicated. For example, we visited a person at 10:00 am then at 11:00 am. Staff had recorded the person was repositioned at 10:40 am. We visited at 15:29, and still the last turn recorded was 10:40 am. When we came to see this person at 17:10, there was a record of a repositioning turn at 14:38. We informed the provider about our findings and there was no reasonable explanation provided. We could not be sure people were protected from the risk of harm and receiving unsafe care.

When people had accidents, incidents or near misses these were recorded on the home computer called Datix. However, these were not monitored to look for developing trends and discussed with the staff team in

an effort to prevent it happening again. The provider did not always review incidents to identify trends so actions could be taken to reduce the risk of recurrence. People involved in accidents and incidents were not always supported to stay safe and action had not always been taken to prevent further injury or harm. We were aware a number of safeguarding issues were ongoing relating to people's health and wellbeing. We could not be assured people would be safe from the risk of emergencies in the home. We asked the service to provide us with the home's emergency plan or procedure. However, we have not received it.

People were not always being protected against risks and hazards, and action had not always taken to prevent the potential of harm. For example, on our first day of inspection we found 10 batteries on charge where fire equipment was stored. The sign clearly indicated the fire equipment was not to be blocked. A hoist was also stored in this area making the fire equipment difficult to get to in a hurry. We pointed this out to the management and the area was immediately cleared. We found the hoist in the same place again on another two days but again this was immediately addressed. It was noted that staff were asked in the handover to stop storing items in that place. We cannot be sure this practice would not be repeated. Until our inspection this has not been identified as poor practice.

People were not always protected against hazards such as falls, slips and trips. We saw there were open stairwells on the ground and first floors. People had free access to all staircases but these were not risk assessed and not recognised as a potential hazard. We were told there were no mobile people in the home thus no falls risks assessments were necessary. However, we saw a person walking unaccompanied with a frame who seemed a bit confused where they were going. There was a risk they could have fallen down the stairs and sustained an injury. There were no signs or safety measures in place to stop them or warn them of these hazards and reduce the risk of falling down the stairs. We saw there was a number of extension leads used in bedrooms however, there were no control measures to ensure and monitor overloading and potential fire risk. We observed general untidiness across the home where various items were stored in inappropriate places. We reviewed records for service maintenance and they were in place. However, the fire risk assessment was out of date. We did not see a current gas safety check had been carried out. We asked the provider to supply us with the appropriate records. We did not receive this.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment was provided in a safe way. They did not assess the risk to health and safety of service users or mitigate such risks.

We looked at the management of medicine in the home. We observed some good practice while staff were supporting people take their medicine. Peoples' medicines were administered correctly. Staff were polite, asked if they were ready for their medicine, explained what it was for and ensured people took it. The medicine administration record (MAR) sheets were signed afterwards. A few people asked for some pain relief and the staff responded to these requests swiftly. The medicine trolleys had always been left locked every time we checked it. However, not all staff who administered medicines had been up to date with their medicine training. Thus people were placed at risk because the provider did not follow their policy to ensure staff were competent at all times to administer medicine.

Peoples' medicines were not managed and stored safely at all times. We reviewed two rooms where medicine was stored on the first floor. The first room had medicine trolleys and mainly special drinks and thickeners to help people with their diets. We reviewed the records kept for one of the trolleys that were in the room. The room temperature had to be checked each day as indicated on the form in the file. However, we saw between 21 January 2016 and 01 March 2016, the temperature had not been recorded on 10 occasions. Staff could not be sure the medicine trolley was stored at the right temperature. The room thermometer was near a very warm wall. The temperature was below 25 C. However, there was a risk the

warmth from the wall may affect the thermometer readings and consequently medicine stored in the room.

We reviewed a number of MAR sheets and a "Drug Administration Error Audit Tool". This tool was introduced to review the MAR sheets at the end of every medicine administration round. If any errors were noted, this had to be recorded in the comments and reported to the line manager. The last entry was on 29 February 2016. There were still some gaps in the MAR sheets where staff did not sign after administering the medicine. These were not noted in the audit tool. Although the tool was a good start to address the issues, it did not work effectively at all times. Staff could not be sure if people had had their medicine or not. One MAR sheet indicated that the application of a certain cream would be recorded in the person's folder kept in their room. When we reviewed this person's folder, there was no topical MAR sheet for that specific cream. Recordings on the MAR sheets and additional forms were not always clear and consistent to show staff were following professional advice. For example, one person needed their blood to be monitored to administer insulin. On the form for blood monitoring, four days had been missed. However, on the back of the MAR sheet those days were recorded. The person's blood test had to be done and insulin injected when necessary at 08:00 am every morning as per MAR sheet. Between 31 December 2015 and 01March 2016 this only happened at the correct time on two occasions. Other times recorded were one or two hours later. The staff were not always managing person's diabetes in line with doctor's prescription and guidelines.

We saw the rooms lacked tidiness and organisation of the area dedicated to medicine management and some items were not stored in the right place. Boxes and tins of food thickeners and drinks were stored in cupboards and shelves. However, there were sticky notes used to indicate old (out of date) and new (in date) stock. This system was not followed appropriately and it did not serve its purpose as all the tins and boxes were in date, so making it pointless. In the rooms there was an assortment of items such as loose drink sachets without names, one sachet had just a number; a closed drinking cup with water inside, a pile of loose gloves, a sling, a travel mug, a tray with plastic, syringes and metal spoons. There was a catheter removal box without a name and two open boxes of needles. All were in date. We found a prescription under medicine boxes in the cupboard where medicine was stored. Items were not labelled and appeared to have been discarded rather than being filed away if still useable or disposed of it not used. While we were reviewing the medicine room, a domestic staff came to clean the room. Although they changed the bin bag, they did not clean the bin lid which was covered with what appeared to be white powder or paint. The hot sink tap was dripping and there were two boxes of used spoons and pots. No one came to clear this up while we were in the room.

We reviewed the clinical room where controlled drugs were stored. Again, the room was very untidy and lots of items were just left on the worktop. The sink area had a box of swab sticks, some washed and some dirty spoons and pots, a blood glucose monitoring system, and two pictures of someone's feet. There were two little yellow bins to dispose of syringes and similar items. The label clearly said "Do not fill above the line". However, we saw the ends of syringes sticking out and the lid could not be closed. The other side of the sink had a pile of medicine of a person who recently passed away, vials to take blood samples, blood monitoring systems, a tray to take blood, wash lotion, boxes of swabs, plasters, calculator, blank MAR sheets and small box of nasal ointment, dated but without a name. The provider did not organise and follow consistently a safe practice and management of medicine.

We reviewed the controlled drugs cabinet. It was tidy and the records tallied with the medicine that was in the cabinet. However, we picked up some discrepancies with recording that may pose a risk of incorrect recording and disposal of controlled drugs. For example, staff did not always record clearly which page the stock count was brought forward to. This led to inaccurate and inconsistent recording causing confusion regarding quantity of medicine. A record in controlled drugs book said an ampule of medicine had been dropped while counting. We asked to see the incident report however provider was not able to provide it.

There was no clear audit trail to account for less medicine than had been administered. Another entry in the book was of a stock check that was not completed. There was a note to say an incident report was filed for it. We asked to see this report but the provider was not able to provide us with the information. A record of certain tablets was crossed out as a wrong entry and signed. The last count was 93 tablets. The next entry was that there were 92 tablets. At 10:00 one tablet was given to the person and the record was still 92 tablets. At 22:00 the same day the stock was recorded as 92 and only after administering the medicine the record was 91 tablets left. The staff recording the 92 tablets did not count the stock and took the last entry as the correct one. This was not safe management and check of controlled drugs.

The main cupboard in the clinical room had a number of medicines all numbered according to what appeared to be the room numbers of the people taking them. However, it was not easy to view the medicines and find the right ones if they needed to be administered. The home was using a lot of agency nursing staff who were administering medicine. This type of storage consumed more time for nurses to find the right box and increased the risk of medicine being lost or administered incorrectly. The provider had had a visit from their pharmacy to carry out an audit. There has also been an internal audit carried out. There were numerous concerns and the provider had compiled an action plan for management of medicines to address all the issues. However, at the time of our inspection we could not be sure all of these issues would be addressed and good practice sustained.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment was provided in a safe way. They did not ensure safe and proper management of medicines.

People were not always protected from the risk of infection because not all areas of the home were kept clean. Some equipment and furniture was dirty and not cleaned properly. For example, during the home tour on the first day we noted that call bell handsets had dirt residue in the join seams and presented a potential infection risk. It was not dealt with until we pointed this out. Later we were informed new call bells had been ordered. However, we could not be sure new call bells would be cleaned regularly and cleanliness maintained. A bath room on the ground floor was last used on 11 February 2016 according to the water temperature book. It had not been cleaned and still had soap scum around it on 17 February 2016. There was a commode chair with rust in the shower room. We were informed new commodes were being ordered. We saw staff wore the same aprons throughout their time supporting people and going in and out of different rooms increasing the risk of cross infection. This had not been identified by management as a potential risk until we pointed it out. In some of the rooms we saw tubs of cream open or without lids, some dated 2014 and they had finger scoop marks in them. Again this had not been identified as potential infection risk. We were aware there were various infections affecting people. Until other professionals had identified this, the provider did had not completed a review to determine if there was a common cause of these infections and prevent them from happening. The practices we had seen in the home increased the risk of cross infection. The service was not following the Code of practice about the prevention and control of associated infection.

The kitchen was dirty. It had not been cleaned for a period of time. One of the kitchen staff went in and out of the kitchen several times. They were wearing a dirty uniform. The washing up area was not cleaned. There was a cigarette lighter and a phone on a worktop surface. A sign on the bin was old and the selloptape was peeling off. We looked under the worktop and saw rubbish under it like an empty plastic bottle and some paper sheets. The floor was dirty. The microwave used in the kitchen was burnt at the bottom. This remained in use throughout the period of our inspection. We checked if it had been changed on our last day of inspection. We saw the microwave used was still the same. On the first day of our inspection in the fridge there was a bowl of soup, cake, two packs of ham, corned beef and beef all sliced open and not dated; sweet

pickle dated 05 February 2016 that should have been used by 12 February 2016. Food hygiene records were not completed and daily checks were not signed. This increased the risk of people getting ill because the provider did not follow appropriate cleaning and safety practices to ensure the food was fresh and safe to eat.

This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment was provided in a safe way. They had not assessed the risk of, or prevented, detected and controlled the spread of infections.

The home used a dependency tool along with care plans to assess the numbers of staff needed on each shift. Staff felt there were enough staff now to do their work. Due to recent changes in the permanent staff team, a significant number of agency staff were working alongside permanent staff. The home tried to book the same agency staff to ensure people got familiar with them and to help maintain consistency in the support and care provided. We received feedback this kind of arrangement did not always work effectively as the staff felt they had to supervise the agency staff at all times. Staff said although most of the agency staff were good and competent, it did take a lot of time out of their day if it was their first shift. They felt they had to supervise them regularly which delayed the care and support provided to people. Staff were aware of recent recruitment being completed which they felt would be a positive turn for the home. People were not sure if there were sufficient staff to meet their needs. They commented 'old staff' left and lots of 'new staff' were in the home which did not make them feel assured about these changes. However, they were positive about the new staff and the support they provided.

There were sufficient numbers of staff to meet people's basic care needs. However, staff were not always deployed in a way that kept people safe. Organisation of staffing did not always ensure people were attended to in good time. They had to wait until staff were free to provide support that people needed. We observed call bells would ring and staff would come to see the person. They would explain to people they would have to wait "a few minutes" or "10 minutes" until staff were back because they were helping someone or doing something else. We could not be sure staff would always come back in a timely way to support people.

It is the legal responsibility of the provider to obtain information to ensure that people are not placed at risk of being cared for by unfit and inappropriate staff. Safe recruitment procedures ensured that people were supported by staff who were of good character, suitable for their role and had appropriate experience. We looked at recruitment files of staff employed recently. The provider checked staff's competence and conduct, and health. The provider also checked criminal records to confirm the staff members' suitability to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK. Two staff files did not fully explore gaps in the employment history. We pointed this out to the home manager. The discrepancies have been rectified and we saw appropriate records were in place.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care and support from staff. Although most of the permanent staff knew the people quite well, staff were not always guided by the best practice and knowledge as they were not up to date with their training. People and their relatives spoke positively about staff and told us they got the basic support they needed however, they did not always have the opportunity to spend quality time with staff.

Staff did not always have the training they needed to meet people's needs and ensure their safety in the home. We reviewed the training matrix provided to us which recorded statutory, mandatory and additional training. There were 48 staff in total. Not all staff's training was up to date. For example, 34 staff had their infection control training booked in March 2016, and eight staff were up to date with their training. Then four out of five kitchen staff did not have their food hygiene training up to date including the head chef, 12 staff did not have safeguarding training up to date, 14 staff needed their moving and handling training updated. Two nurses and the deputy manager who were administering medicine needed to update their medicine competence. In the management of medicine policy training section it was written that staff administering medicine should have their competencies assessed at least annually or more often if necessary. Other nurses on the training matrix were indicated as 'Not applicable' so it was not clear if they had or did not have their training. We did not have information for 10 staff regarding their training. No information was available about any staff working towards qualifications appropriate to their role. Therefore, we could not be sure staff were enabled to obtain further qualifications appropriate to the work they performed and enhance their skills.

Mandatory training included role specific themes like person centred planning, challenging behaviour, safe handling of medicines, nutrition, communication, care planning, risks, dementia awareness and pressure ulcer management. No staff were recorded on the matrix as having completed any of these training sessions despite the fact that there were people living in the service who had these support needs. People and their relatives had mixed views about the skills and caring nature of some staff. Comments included: "Staff do not pay much attention to [name]", "We had a few snags but staff are caring and nice", "It's a very sad place", "Staff look after me well and I feel comfortable here" and "Oh they [staff] are good".

People were supported by staff who had not had supervisions (one to one meetings) with their line manager. We reviewed the new system put in place since the new manager started. It was a matrix with some dates planned. Only three meetings had been held. The home manger said that prior to them coming to the home these meetings had not been carried out regularly. Supervisions were not used to ensure staff had time to review their performance, professional development and discuss any matters. It was used more as a disciplinary tool rather than mentoring and supporting staff in a positive way. The management therefore, had no overview of staff performance and development needs. This had led to a culture in the service where staff were not clear on their roles and responsibilities which, in turn, meant that people were not always getting appropriate care and support. We could not be sure that the matrix would be followed and this would be sustained. However, the home manager told us they were encouraging staff to come to them or the clinical facilitator if they had any questions or issues. Staff confirmed both the home manager

and clinical facilitator were very supportive and encouraging. Some said they were still at the home because of them.

This was a breach of Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure staff supporting people were appropriately trained, supervised and be able to obtain further professional development in order to perform their work.

People told us they were able to make choices about what they had to eat. We received a mixture of feedback regarding the quality of food provided: "There is a choice but it is ok, not my thing", "Oh they [kitchen staff] are good", "The food is very nice and I get plenty to drink" and "It's only OK, not good". People were offered a choice from the menu for their meals for the following day. Other options were available if they did not like what was on the menu. The staff were aware of people's dietary needs and preferences. Staff told us they had the information they needed and were aware of people's individual needs. However, people's needs and preferences were not always clearly recorded in their care plans. The kitchen staff did not have up to date information regarding people's diets and some people's meals were not prepared according to their likes or professionals' advice. For example, one person needed a soft diet due to a recent choking incident. However, we saw they were offered solid foods. There was a drink on a side table in their room but the chart in the room clearly indicated this person needed assistance with drinking. The last record of food and fluid offered was 11:25 am. At 15:25 nothing more had been offered according to the records. This put the person at risk of receiving inappropriate food and insufficient fluids.

On the fourth and fifth day of our inspection we observed the lunch in the main lounge. In this part of the report we will use lunch one and lunch two to describe our observations. Lunch one started late and people and staff were commenting on this throughout the lunch. We saw no clear leadership from staff to ensure people had their meals on time. People who did not require support to eat were served first whereas people who needed help eating were left to be served last. Some people eating in their rooms had their lunch very late in the day. We observed inconsistent practices where staff were serving food then were helping someone to go out of the lounge. Then staff went back to serving food. There was no consistency in serving people their meals. We observed and heard staff were stressed as not everyone knew what to do. Although the lunch time was chaotic, we observed some good care and support, as well. Staff helping people eat were kind, encouraging and respectful. They were helping people eat at their own pace and had a chat with them. Everyone was offered drinks of their choice, asked if they had finished their meals and what was their choice of pudding. Some people chose to eat in their rooms however they received their lunch late for example we saw one person had their lunch at 13:49. We found another person had not had their lunch and staff were unaware of this until we informed them. They had their lunch at 14:30.

Lunch two was not as late as lunch one although some people still made a comment about it. The atmosphere was less chaotic and people were eating their meals at their own pace. We observed a mixture of practices. People were asked if they had finished their meals and their choice of pudding. Again those who needed help eating were served last. Eventually they had staff helping them to eat and it was done in a polite and kind manner. Staff did not rush them and had a small chat with people. We observed staff explaining to one person what was on their plate and ensured they were happy to eat it. Condiments were offered with the meal, some people were asked if they wanted gravy and some people were just given it without them agreeing. People were not always supported to have a meal of their choice by organised and attentive staff.

This was a breach of Regulation 9 (1) (3) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider did not ensure the nutritional and hydration needs of service users were met in time, appropriate to their wellbeing and support was provided.

People's changing needs were not always monitored appropriately to ensure their health needs were responded to promptly. People were not always referred appropriately to the dietician and speech and language therapists (SALT) if staff had concerns about their wellbeing. Only on our last day of inspection were we informed all people who would require a special diet had been reviewed again to refer them to SALT to ensure they have an appropriate and correct diet. People had access to health and social care professionals. Records confirmed they could access GP, dentist, psychiatrist and an optician. They were supported to attend appointments when required. However, due to inconsistency of recording and reporting of the illnesses or health deterioration, people were not always referred to health professionals in a timely way. There was no continuity between recording and providing care and treatment to people. We found examples of illnesses or health deterioration which were identified but not acted on immediately. For example, one person had diagnosis of eyesight disorder. On 25 February 2016 daily notes indicated the person had a red eyelid. However, we did not see any care plan or intervention had been instigated to address this. Care plans were in place to meet people's needs in different areas. However, they were not regularly reviewed. People did not always have appropriate care plans to help them and staff look after their specific conditions. For example, a person came to live in the home last year in June. They had an eye condition which required monitoring and specific care. However, a care plan to look after their eyes was only made at the end of January 2016. They had suffered some eye infections as a consequence because staff were not aware of how to properly support this area of their care and support needs.

People's health care needs were not always met effectively. There were people using catheters. However, they did not have an appropriate catheter care plan to ensure it was looked after well and to reduce the risk of illness or infection. One person suffered from a bad skin condition recently. We found a picture, with a date 13 January 2016, but little recorded in the notes about it. They had been prescribed a cream to help the skin condition. The notes suggested that this started on 09 February 2016. However, there was no record that the cream application had commenced on that day. Staff were not aware of this and could not produce a topical MAR sheet. Only later the nurse found a MAR sheet that appeared to be for that cream which actually started on 05 February 2016. There was no information or explanation of why there was a gap of 23 days between the condition being noticed on 13 January 2016 and treatment starting on 05 February 2016. There was also a person declining medicine, and GP reviewed them for this reason. However, there was no up to date information how best to support this person to take their medicine. Another person had a swollen hand but the care plan for looking after it was recorded in an infection control section. We did not receive reasonable explanation of reason for this information being in this section. Another person did not like lying on their side due to breathing problems. We were told a pillow was used to move them to the side slightly. However, the person remained on their back for a long time between 11:15 and 14:30. There was no pillow and no care plan to guide staff so they could provide appropriate support to increase the person's comfort while managing potential pressure damage from remaining in the same position for long periods of time. People's health care needs were not always monitored thus any changes in their health or well-being would not always prompt a referral to their GP or other health care professionals. The disjoint between records and actions put people at risk of their health failing rapidly. We received feedback from external professionals. They were positive about the home and staff working and supporting people. However, they felt staff's knowledge and skills varied which affected people's support and time to respond to their needs.

This was a breach of Regulation 9 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure people's care and treatment was appropriate and met their needs at all times.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. It was recorded in the care plans the person and their family were involved in the planning of the care and support.

People can only be deprived of their liberty in order 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 are called the Deprivation of Liberty Safeguards (DoLS). We looked at the information to find out if there was anyone living in the home who was subject to a DoLS authorisation. The home manager told us applications had been made for people. Two out of seven people referred had DoLS in place. One person's DoLS expired in January 2016, we could not see if this had been reviewed and extended or not. We asked for more information to find out if all the people had been reviewed regarding DoLS authorisation recently. We did not receive sufficient information about all people who were deprived of their liberty to determine that this had been done in a lawful way. We could not be sure the service had followed the principles of the MCA prior to judging whether the person was being deprived of their liberty or not.

People's rights to make their own decisions, where possible, were protected. Some staff had received training in the Mental Capacity Act 2005 (MCA). Training was in progress to ensure all members of staff were trained in MCA. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We observed staff were asking for consent and giving time to people to respond. People's decisions were respected and acted upon. Staff we spoke with were aware of their responsibilities to ensure people's rights to make their own decisions were encouraged and promoted. Care plans we reviewed had capacity assessments and some of them included best interest decision making meeting minutes. We saw some records were signed by the person to consent to the care and support and some were left blank. In those instances there were no recorded explanations as to why it was not signed so it was not clear if the person had given their consent.

Staff told us they had felt supported working at the home by the management. However, they also said communication within the home was not always effective and certain things were missed. One staff member said: "[The home management] is very pleasant", "The home manager supports in every way, we are here because of them, all staff, we work as a team" and "They are very supportive". New staff were supported to complete an induction programme before working on their own. We saw they were working alongside the more experienced staff and supporting people were they could according to the induction process. For example, a new member of staff was helping during lunchtime by placing cutlery on the tables. Some people asked for some help with their meals. The staff went to get someone who could provide support as necessary.

Requires Improvement

Is the service caring?

Our findings

We received a mixture of feedback from people and relatives about people's care and treatment. Some people told us they were not always happy with the care they received. People's care was rushed at times not enabling staff to spend quality time with them. Some staff told us they did not have time to spend with people and get to know them as an individual. Staff did not always ensure people were not being neglected or left in undignified situations. For example, we were aware that concerns had been raised regarding two people and the care of their nails. We saw both of them had very long and dirty nails. When we asked staff about one of the ladies nails, we were told staff tried a few time to look after the nails but the person was refusing support. We reviewed the daily records for this person and saw no record of such support offered or a refusal of it. When we went back for another day of inspection, we saw the person had had their nails done and it was recorded in the daily notes. However, another person still had long and dirty nails and nothing was recorded in their daily notes regarding this.

People received care and support from staff whose knowledge varied about people and their needs. We observed the relationships between staff and people receiving support did not always demonstrate dignity and respect at all times. For example, one person was left waiting in the corridor because staff went to get the hoist as they needed to use the toilet. The staff waited by the hoist rather spending time with the person ensuring they were alright with the waiting time. When staff came back, they spoke kindly to the person but loudly so that everyone could hear the person was going to the toilet. This was not discreet and it did not protect the person's dignity.

Staff did not always know, understand and respond to each person's diverse needs in a caring and compassionate way. When we spoke with staff, they were knowledgeable about things people found difficult and how changes in daily routines could affect them. People's records included information about their personal circumstances and how they wished to be supported. However, we observed this was not always followed. For example, one person who normally had their medicine after breakfast had been given their medicine before breakfast that day without an explanation and it really confused them. They did not know why it was this way and it really troubled them.

Staff did not always show concern for people's wellbeing in a caring and meaningful way and did not respond to their needs quickly. There was a mixture observations of how staff supported people who could become anxious and exhibit behaviours which may challenge others. For example, we met a person in a corridor who was upset and confused. We helped them to calm down and offered them a drink. They told us they could not hear us although their hearing aid was in place. A staff member came to ask them if they wanted any lunch but the person could not hear anything. We questioned if the hearing aid was working which staff replied: "Yes, it is working". They wrote a note to the person but he could not read it, even with his glasses. The staff member left him. Later we saw this person wandering in the dining room and it was not clear if he had had any lunch. Staff helped him go to the sitting room but did not stay to talk to him and ensure he was alright. Staff knew people's individual communication skills, abilities and preferences but did not always follow their knowledge or take time when a person was clearly distressed to reassure them.
We saw from the corridor one person was in bed and their blanket was slipping away uncovering them more

and more. This could clearly be seen walking past their open door. Some staff walked past and even entered the room but did not appear to notice the person was uncovered. We pointed this out to the home manager who immediately took action to ensure the person was comfortable and dignified.

This was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that service users received care and treatment that is appropriate, meet their needs and reflect their preferences.

We also observed that there were times when people were treated with kindness and compassion when staff were supporting them. There were examples where staff spoke calmly and politely giving people time to respond. Interactions we observed between some people and staff were gentle and kind. Staff knocked on the doors and waited for permission to enter the room. Staff always asked people for their consent before doing things. People had an opportunity to make choices where appropriate. Occasionally people became upset, anxious or emotional. We observed some interactions where staff were polite, supportive and patient. They would kindly explain the situation and the next steps they would take in order to support the person. For example, one person became very upset as they thought the staff were taking them to their room. Another staff member approached the person and explained this was not the case. They were getting ready to support the person to use the toilet as they initially requested. The person calmed down and went off with staff. Another person was concerned about the amount of people and changes going on in the home. However, they told us the management had been to see them which helped them lower their anxiety levels and enjoy their stay.

People's bedrooms were personalised and decorated to their taste. We saw their rooms were personalised with pictures of friends and family, paintings, flowers, favourite books and other items important to the person. The home was spacious and allowed people to spend time on their own if they wished. We observed people and their appearance. They looked well cared for with clean clothes, men were shaved, ladies wore jewellery and scarves, and people wore appropriate footwear.

A few people were receiving end of life care and palliative care. People and their relatives were given support when making decisions about their preferences for end of life care. We reviewed one person's support for palliative care and support was in place. The person was looked after and their needs were met. Another person who was receiving end of life care support did not always receive the care they needed. The family had to complain several times before appropriate care was put in place and provided as needed. People's care and support were not consistently recorded and acted upon. Some people had signs in their rooms informing staff about their support, likes or dislikes. We observed and were told staff did not always pay attention to these. Thus people did not receive the care and support they preferred. We observed the organisation around providing end of life care was not always appropriate. The records of people's care and support were not always accurate and up to date. For example, the person had a catheter but no care plan was in place. There was no reference to person's wishes regarding their end of life care. The care and support for someone at the end of life was more reactive rather than proactive. We did not see that the staff appreciated the need of good end of life care.

Requires Improvement

Is the service responsive?

Our findings

People were not always at the centre of the care they received because staff sometimes focused on the task, rather than them, as individuals. Staff seemed to be aware of people's needs but did not always respond in good time. For example, we visited a person in their room as we had heard them calling staff for a while. The person was in bed with their bed table tipped over, no call bell in reach or to be found nearby attached to the bed. The person was distressed and called for a drink and their handbag. They were confused and we were unable to reassure them. We found staff and asked them to help the person to calm them down. We returned in about 10 minutes but the person was in the same state, no staff present. Only after almost an hour when we returned they were calm and settled. Another person asked to be taken to another room. The staff said they would come back shortly to which the person agreed. The person did not have to wait long and staff helped them to go where they wanted to. On our visits we observed call bells ringing continuously in the morning and the time taken to respond was varied. Later in the day the bells were ringing quite often but the time to answer was much quicker.

People or their relatives were involved in developing their care, support and treatment plans. Care plans detailed daily routines specific to each person and their preferences. Speaking with staff they were able to explain how they supported people. However, people did not always receive individualised care from staff. We observed that practice was often task led rather personalised to the individual and did not follow what was described in their care plans. Some staff felt they did not know a lot about the person except how to meet their basic needs. Staff had access to a range of training to develop the skills and knowledge they would need to meet people's needs. However, the staff did not always have the opportunity to attend the necessary training to develop their skills and knowledge. People were being supported by staff whose skills and knowledge was not maintained up to date regularly.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care. However, care plans were not always personalised. Information in these records was not always clearly explained or information was missing about how care, treatment and support should be provided. Each file contained information about the person's basic care needs and support they needed. There was some information about likes, dislikes and people important to them. However, this was not used to create a file personal to each individual about their life, care and individuality to enhance the quality of their life. Some staff told us they knew people's basic needs but they were not always sure what the person liked or what their interests were.

People had a range of activities they could be involved in but the activities were not tailored to each person living in the home. People were able to choose what activities they took part in. We spoke to a member of staff who was acting as the activity coordinator in a part time role until the new person started. They were very passionate about their work with people and spoke with great care about the work they did. People were also very positive about their work. In addition to group activities, people were able to maintain some hobbies and interests however staff did not always provide support as required. For example, we had a nice conversation with a person who loved reading books. They were able to tell us on a few occasions and on

different inspection days about the books they had read and the content of them. However, the person barely got out of the bed. We did not observe or read in their daily notes that staff tried to encourage this person to get up or do something related to their hobby. We spoke to a few people who felt quite lonely and isolated because staff did not have time to spend with them. All of them were able to engage in conversation easily. They would have benefited greatly from various activities tailored to their interests or hobbies. We were aware a new activity co-ordinator had started with the company. They showed us their plans to engage people in various activities. They wanted to ensure each person had an activity that would interest them. However, we were unable to confirm this would happen and that people would be involved in the meaningful activities regularly.
People's needs were not always reviewed regularly and as required. For example, a person was declining food and their medicine. They had been seen by GP a few times. However, we saw the care plan to support the person and follow GP's advice was not up to date with the most current information. Weekly weight charts were up to date however nutrition care plans did not reflect the refusal of food or possible requirement of enriched diet. Where necessary the health and social care professionals were not always involved or referred to in time

Care plans did not always include information that enabled the staff to monitor the well-being of the person. Where a person's health had changed it was not always evident staff worked with other professionals to ensure they received appropriate care and treatment. For example, some people had to be regularly monitored regarding their skin condition, choking or eating. This was not done at regular intervals to ensure changes were picked up and acted upon. This increased the risk of poor outcomes for people and their health.

This was a breach of Regulation 9 (1) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure care and treatment met people's needs and reflected their preferences at all times.

Handover between staff at the start of each shift was used to ensure important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. However, we observed the handover and organisation of work did not always work well. As the home was operating with high number of agency staff, it was important to ensure all the staff knew what to do and where. Although agency staff were asked to 'buddy up' with permanent staff, we observed staff were confused and were not sure who was working where. We observed that staff did not always have the opportunity to ask questions once the handover was finished. Staff did not always know what to do or where to be which affected people's care and support.

Complaints and concerns were taken seriously but we were not sure it was used as an opportunity to improve the service. There had been four complaints this year and these were being investigated thoroughly. We saw the provider responded to all complainants in writing assuring them appropriate action would be taken. However, we could not confirm at the time of our inspection the actions were complete and people were satisfied with the outcome.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid some social isolation. We observed a number of relatives visiting people throughout our inspection. People could stay and spend as much time as they wanted with their relatives in their rooms, lounge or dining room.

Inadequate

Is the service well-led?

Our findings

The service had a home manager who was in the process of becoming a registered manager of the service. The provider had notified CQC about significant events. We used this information to monitor the service.

At the time of our inspection, we observed there was no clear leadership within the home. In response to concerns identified by the local authority an additional team of management was deployed at the home. Despite this the progress of addressing the issues was slow and little was evident. We received feedback from other professionals that even though there were extra staff to help address the issues, things were not improving as fast as they should with the amount of resources provided to the home. The leadership was reactive rather than proactive and we had to point things out before action was taken. For example, the kitchen remained dirty even though an infection control review had been carried out. The service did not always identify and manage risks effectively to ensure people who use the service received safe and appropriate care and treatment. The support and resources needed to run the service and address ongoing concerns were available but not effective. Due to constant management changes staff were not always clear who they were accountable to and which duties to perform first. We observed staff and nurses were asked to leave what they were doing, for example, serving lunch and go to assist someone with another task, for example, to help someone to go to the toilet or complete certain paperwork.

People did not benefit from high quality and person centred care because the management of the service was not robust. The provider had reviewed aspects of care and support in the home, for example, safety, medicines, infection, care records and other issues. An improvement plan report was completed which detailed the issues, actions to be taken and date of completion. We were concerned the majority of tasks to complete had been assigned to one person which was an unreasonable workload to complete each task on time. The issues identified were ongoing and the lack of organisation and management of resources like extra senior staff became evident throughout the inspection. Systems to monitor peoples' experience of care did not appear to be effective or appropriate, and this led to issues remaining unresolved.

The home's aims and objectives were to provide people with excellent support. We reviewed the provider's 'new approach to care'. We also reviewed systems the home used to assess and monitor the quality of the service that were designed to ensure people's health, welfare and safety. Many areas of the service needed to be reviewed and improved. For example, responding to people's needs, making sure staff were using assessments correctly, maintaining a clean and safe environment and being involved in meaningful activities. The provider had policies and procedures available to give guidance to staff on how best to support people. However, the practice in the home did not always reflect the approach and guidance available.

Staff had defined roles but did not always understand their responsibilities in ensuring the home met the desired outcomes for people. We saw that some people and staff had good and kind relationships and there were examples of good communication. We observed friendly interactions and respectful support provided to people. However, not all staff understood the importance of respect and dignity. From speaking with staff we could see they were interested and motivated to make sure people were looked after well and able to

live their lives the way they chose to. We observed some good practice. However, during the inspection we also observed some practice that was poorly managed. We observed the organisation of staff and their work did not always have a positive effect on people's support and care.

The provider had a system to manage and review care plans and risk assessments, and other home management records. However, records were not always completed accurately or altered when necessary. For example, when people's health, needs or their skills changed, when health and safety checks were carried out, when infection control tasks were completed or when staff support was carried out. Therefore the provider did not always have an accurate overview of the care and support requirements to ensure people and staff were protected against the risks of unsafe or inappropriate support and practice. We also observed people's records were left in the dining room without any staff present. We could not be sure staff treated the information about people confidentially and with respect at all times.

We identified concerns that people were not always protected against the risks associated with unsafe and inadequate monitoring and assessment of the quality of the service provided. Quality assurance systems were in place to monitor the quality of service and the running of the home. However, these systems were not always effective. We identified a number of concerns that these systems failed to recognise. For example, internal audits had identified shortfalls but action had not been taken swiftly at all times. Staff reviewed care plans and room documents to ensure recordings were up to date and reflected the care and support provided. However, we saw people's records were not always current and things were being missed out, for example, people's repositioning and food and fluid intake. There was confusion between some members of staff who was responsible for checking the documents were accurate and up to date.

We reviewed recent quality assurance audits. Although it has noted a number of issues with the documents, like information missing, the audit was not informative and comprehensive. There was no action plan attached to it. There was no evidence to demonstrate issues identified had been addressed immediately or work was in progress. We did not see and did not receive any information on a clear system to monitor, review and ensure that where people were deprived of their liberty, this was done in a lawful way. We reviewed other audit tools used within the home. Although some audits identified discrepancies it was not evident if they had been reported and shared within the team or what action had been taken. Some audits had not been done since December or November 2015.

The systems for monitoring, assessing and improving the service being delivered were ineffective. Appropriate measures were not being taken to consistently identify and mitigate risks for people living and working in the home. For example, there were gaps in the medicine administration records. Although a new medicine audit tool had been implemented, not all omissions had been identified or acted upon. In another example one person did not like being on their side while in bed due to breathing problems. A pillow was used to slightly move them to the side. This was not evident during our inspection. There was no care plan in place in order to direct staff with regard to the person's respiratory problems. The person was lying on their back every time we visited them apart on one occasion slightly sat up to eat. The gaps and missing information in people's records increased the risk of health and skin issues. This was not identified in any audits or acted upon in a timely manner. Another person's weight was decreasing so they had to be weighed weekly and their food intake monitored. The last weight check was done on 25 January 2016. We asked to see the weekly weight charts however the staff were unable to produce them. We could not be assured people were receiving the care and support they required to improve their health. We could also not be assured the provider had identified that this aspect of the service needed improving.

We visited the kitchen and it was not kept clean. We saw the daily checks were not carried out. Kitchen staff did not recognise their working environment was a potential risk of infection and illnesses. A day before our

inspection the provider carried out infection prevention review but the kitchen was not included in the review. We were not given reasonable explanation why it was missed. We found out that the management was under the false opinion the service was no longer responsible for the kitchen and kitchen practices due to contracting out to external caterers. Under Regulation 15, providers retain legal responsibility when they delegate responsibility through contracts or legal agreements to third parties including contractors. They must therefore ensure they meet the regulation as responsibility for any shortfalls rest with the provider. In this case, the provider did not ensure there was no risk of illnesses to people when the food was prepared in the kitchen.

Quality assurance and satisfaction surveys had been sent out to people living in the home, their relatives and healthcare professionals recently. The results were not available yet so we were unable to review this or any action plans drawn up. We did see a survey from last year. There were only charts and some comments provided. We did not see any analysis of the results and action plans created or acted upon. Some of the responses were generally positive. However, it was not clear what action was planned or had been taken to improve the quality of the service for people where negative responses had been received.

Staff have had some meetings and discussed different topics including practice at the home, care and support of people, care planning, safeguarding, medicines and training. Relatives and people using the service had also had some meetings. However, they were not regular. We were given a list of meetings already scheduled throughout the coming year. The dates and weekdays varied as per requests of relatives. People, relatives and staff said they could raise any issues with the management. We received a mixture of reviews that some issues were addressed swiftly but some had to be repeated a few times. Relatives said the team and the home management were friendly and approachable. People and those important to them had opportunities to feedback their views about the home and quality of the service they received. However, we did not see people, relatives and staff were empowered to contribute to improve the service at all times using their input.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not established and operated effective systems or processes to ensure compliance with this regulation.

Staff were aware about the ongoing issues in the home. They were positive these would be addressed. The home management was honest and open to staff regarding the issues. They felt the home manager was supportive and encouraging. The home manager and clinical facilitator regularly worked alongside staff which gave them an insight into their practice and how best to support the people. The home management were developing the staff team to consistently display appropriate values and behaviours towards people. They felt there was some progress but still a lot of work had to be done. They praised the staff for their willingness and support to address the issues and sort them out.

The service did not always have a positive culture that was person-centred, open, inclusive and empowering. It did not always show there was a well-developed understanding of equality, diversity and human rights and put these into practice. The home manager had recognised the challenges of ensuring the staff worked as a team and supported each other. They promoted a positive culture and tried to engage staff in reflecting on practice and any lessons to be learned. The culture in the home used to be quite negative and it affected the way staff supported people and worked with each other. The home manager and clinical facilitator were working with the nurses and other staff to remove the institutionalised practice and task orientated support. In addition to this, they explained how they were continuing to work with staff using reflective practice. They felt if led by example with good practice, staff would understand and learn from mistakes more effectively. Staff felt things were improving, and there was more conversation, willingness to

support each other and more improved morale.

Recently quite a number of permanent staff had resigned which increased the number of agency staff used. Consequently this had impacted on the way the home was organising and leading the shifts. Most of the permanent staff were positive about the agency staff. They also noted this affected their daily work as they had to ensure the agency staff knew what to do. The agency staff gave positive feedback about the support they had received from the provider to ensure they know their duties.

Staff told us they felt it used to be a quite sad to work in the home and due to workload and shortages of staff, they were quite negative. However, they reported that things were improving in regards to team work and supporting each other. Staff spoke positively about the home manager and clinical facilitator and how they were helping staff, encouraging them to work together and not to give up. Staff said the home manager was responding well to the requests or concerns they have raised with them. Staff were very pleased the management tried to maintain the same agency nurses and care assistants as it helped the home run smoother. Staff were sure the issues and concerns raised were shared with them and they felt the management was open and transparent with them about what was going on. They understood things needed to be addressed and staff were happy to help where they could. Staff were positive that issues would be addressed appropriately and the managers will continue to empower staff team development and drive improvements.

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 did not take formal enforcement action at this stage. 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 (1) (a) (b) (c) (3) (i) The provider did not ensure people's care and treatment was appropriate, met their needs and reflected their preferences at all times.The service provider did not ensure the nutritional and hydration needs of service users were met in time, appropriate to their wellbeing and support was provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (g) (h) The provider did not ensure care and treatment was provided in a safe way. They did not assess the risk to health and safety of service users or mitigated such risks. They did not ensure safe and proper management of medicines. The provider had not assessed the risk of, or prevented, detected and controlled the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (2) (a) (b) The service provider did not ensure the staff received appropriate training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The service provider could not provide

sufficient information they enabled their staff where appropriate to obtain further qualifications appropriate to the work they perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (e) (f) The service provider had not established and operated effective systems or processes to ensure compliance with this regulation.

The enforcement action we took:

Warning Notice to be served