GCH (Hertfordshire) Ltd

Autumn Vale Care Centre

Inspection report

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 03 and 10 May 2018 and was unannounced. This was the first inspection of Autumn Vale Care Centre under the new provider GCH (Hertfordshire). GCH (Heath Lodge) was changed as a legal entity to GCH (Hertfordshire) in June 2017. Prior to registering with the Care Quality Commission (CQC) there were breaches of regulation in relation to the management of the service.

Autumn Vale is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. They are registered to provide accommodation for up to 69 people for older people including people with dementia. At the time of our inspection there were 45 people using the service.

Autumn Vale Care Centre accommodates people across five separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia, one provides residential care with the remaining three units provides nursing care. At the time of the inspection the provider had taken a decision to close 'Blue' unit to enable them to review their staffing and training arrangements.

The service had a manager who was not registered with the Care Quality Commission (CQC). However, they had submitted their application and were awaiting an assessment to complete the process. 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 and associated Regulations about how the service is run.

People told us staff were kind which in turn helped them to feel safe. People and staff told us there were sufficient staff to provide care, however deployment of staff, particularly those in leadership roles was not effective. Risks to people's welfare were managed inconsistently and appropriate equipment was in place but not always used to support people's mobility needs. People were supported by staff that had undergone a robust recruitment process to ensure they were suitable to work with vulnerable people. People's medicines were managed safely and people received their medicines as the prescriber intended. The home was clean and staff ensured they followed infection control guidelines when providing personal care. Staff did not routinely review their practise to learn lessons from significant incidents of safeguarding concerns.

People were supported by staff who were trained in core areas of care and managers who had received specific leadership training, however staff were not consistently provided with sufficient opportunity to further develop their skills. Care staff received regular supervision of their conduct and practise, however gave a mixed response about feeling supported by management. People's consent was sought verbally when offering care and support to people but not always documented appropriately. The service did not always work in line with the principals of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) where people lacked the capacity to make their own decisions. People were happy with

the support given to them to maintain their weight and hydration and staff took appropriate actions to support their welfare. People were supported by a range of health professionals who supported people's needs as they changed. The environment of Autumn Vale did not always support people to use the facilities and support those people living with dementia to live in a well maintained and supportive environment.

People and relatives told us that the service was caring. Staff demonstrated a caring attitude when talking about people and were able to describe in detail to us how they assisted people in an individual manner. People told us that staff had built meaningful relationships and responded positively to them when they felt anxious or agitated. People told us that the attitude and care provided by staff had a positive impact on their life.

People told us that the service they received was responsive to their needs. People told us they made their own decisions which were respected by staff who then supported them to retain as much of their independence as was possible. However, assessments of people's care did not demonstrate that people's views were routinely sought. Social activities were not consistently organised across the home, particularly for those people who spent their day in their rooms. People gave mixed views about raising concerns or complaints with the management team, however those concerns that had been raised had been addressed.

Autumn Vale lacked leadership from a consistent manager having employed three managers since the service registered in May 2017. This had negatively impacted on staff morale and leadership in the home. The service had now recruited a manager who was in the process of registering with CQC and who had identified many of the concerns found at this inspection. The provider and registered manager carried out regular audits in areas such as medicines, care planning and health and safety. In addition, an external assessor reviewed the quality of care people received. However, these audit tools had not been effective in identifying the concerns we found at this inspection. People's care records were not reflective of their preferences, or did not always document robustly how to provide care to people. Notifications that were required to be sent to CQC of significant events were made in a timely manner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they felt safe. Staff were aware of how to keep people safe from harm, however incidents were not always investigated or responded to appropriately.

Risks to people's welfare were not consistently managed. Equipment people had been assessed to use for transfers was not always used.

People's views about staffing levels in the home were mixed. Senior staff were not effectively deployed.

Staff did not routinely learn lessons from incidents or near misses.

People's medicines were generally well managed and people received their medicines as prescribed.

People were protected from the risk of infection and lived in a clean and hygienic environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training in key areas, however opportunities to develop their skills further were limited. Not all staff we spoke with felt supported in their role by senior management.

People's consent was obtained when staff provided care, however was not appropriately recorded in people's care records.

The legal requirements of the Mental Capacity Act 2005 had not consistently been followed.

The grounds had not been maintained around the home and the internal environment did little to support the needs of people living with dementia.

People's weights were monitored and staff were aware of people's specific dietary needs.

People had access to a range of health professionals when they needed them.

Is the service caring?

Good

The service was caring.

People were cared for in a kind and compassionate way by staff who knew them well and were familiar with their needs.

People and their relatives were involved in the planning, delivery and reviews of the care and support provided.

Care was provided in a way that promoted people's dignity and respected their privacy.

People's confidentiality of personal information had been maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People told us their needs were responded to promptly. Staff demonstrated their awareness of people's current care needs.

Social activity and inclusion was limited and not consistent across the home.

People and relatives were not all confident to raise a complaint or concern.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider demonstrated a clear approach to care, however this had not been demonstrated on the day of our inspection.

People, staff and relatives gave mixed views on the leadership and management of the home. However, people, relatives and staff were positive about the recent appointment of the new manager. The management changes had caused a feeling of low morale among the staff team.

Staff meetings had been held however staff told us these were

not productive or positive.

The provider had systems in place to identify areas of improvement needed, however our inspection identified further areas that the provider or manager were not aware of. Actions were taken during the inspection to address identified concerns.

People's care records were not consistently accurate and did not always provide staff with sufficient information to provide person centred care.

Notifications that are required to me submitted to CQC were made without delay.

Autumn Vale Care Centre

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 03 May 2018 and was unannounced. Due to concerns identified on the first day we followed up with an announced visit on 10 May 2018 to ensure action had been taken. This was the first inspection for this location under the new provider GCH (Hertfordshire). The inspection team was formed of two inspectors, a Specialist Nursing Advisor and one 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 service.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events, which the provider is required to send us. The service had previously been inspected under their previous registration. Following that inspection, they sent us an action plan setting out how they would make the needed improvements. We reviewed this plan to help us check on their progress. We also received feedback from representatives of the local authority health and community services and safeguarding teams.

During the inspection, we observed staff support people who used the service; we spoke with 12 people who used the service, two people's relatives, 13 staff members, the newly employed manager, representatives of the senior management team and the provider. We spoke with two visiting health professionals. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex needs.

We reviewed care records relating to nine people and other records central to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe living at the home. One person said, "I do feel safe, they've given me the gate across my door to stop other residents walking in." One person's relative told us, "When [Person] uses the buzzer during the day it's answered promptly. The day staff are lovely. They keep [Person] safe and look after them well."

Staff were knowledgeable about how to keep people safe from harm. Staff told us they received safeguarding training and they knew how to report their concerns internally and externally to local safeguarding authorities. They were able to tell us possible signs of abuse and how to document and report their concerns. All staff spoken with were clear on how to raise their concerns following the organisations whistleblowing policy. One staff member said, "I would report anything I saw that I felt was not right, of course I would whistle blow. I wouldn't keep my mouth shut."

However, we found a person who was particularly prone to bruising. Staff recorded and reported unexplained bruising, and this person's body map noted numerous bruises that had been documented in the map to record the location, but not recorded in the persons daily care records or care plan. Recent bruising or skin abrasions had not been photographed to track the healing of the wound. The recording of new bruising or skin tears was difficult to decipher as staff had repeatedly updated the one body map. We saw an entry from one staff member two weeks prior to the inspection that read, "Numerous skin tears, difficult to tell if old or new." This meant that not all the bruising or skin tears had been appropriately documented, and were not always discussed or reported by senior managers for an investigation to be carried out to establish the possible cause.

Risks to people`s well-being were not consistently managed by staff. We found some positive examples of how staff supported people's needs well. For example, one person had an existing pressure sore when they moved into the home. Care records had been completed and the appropriate equipment, positioning and preventive measures were taken to promote healing and good skin integrity care. The sores were healing well and we saw where staff had informed the relevant health professional to review. We found further examples of good care in relation to skin integrity that mirrored the previous example, but in all areas found need for improvement. For example, where the care to people with pressure wounds had been good, we then found pressure mattress settings on both days were not correct for five of nine people reviewed. We spoke with the senior management team and manager about this who took immediate action to address the settings and ensure they were correctly maintained. However, this was an area that required improvement. Where the overall approach to pressure care had been well managed overall with people's wounds healing, not having pressure mattresses set correctly placed people at risk of rapid deterioration when in bed.

Risks to people's safety and welfare in relation to those people at risk of falls were not consistently managed across the home. For example, one person had a profile bed, bed rails and sensors for use in bed. This sensor was also required to be used on every chair the person sat on. The risk assessment noted, "Staff to check sensors are in place and are in order. If [Person] has a fall senior on duty to check for any injuries, if

not sustained an injury follow correct guidelines and inform NOK, clear any hazards." There were no guidelines about how to support the person, either with their mobility or managing their pressure areas. This meant staff were not consistently aware of how to support this person to mitigate the risks. For example, this person was seen sat in the lounge, their walker was placed behind the television out of reach. When they attempted to stand, setting off the sensor alarm, staff encouraged the person to sit down. Only on the second occasion did a staff member support them to use their walker. There was nothing recorded about the walker to be kept close and staff to assist to use it.

Where it was recorded, staff did not always follow people`s assessed moving and handling instructions. For example, on Peach unit we observed one senior staff member helping a person out of their chair alone. The person was not supporting their own weight and another staff member came to assist. No equipment was used, however the persons moving and handling assessment said they required to be assisted by using a standing hoist. Later in the morning the hairdresser took a person to the salon in their wheelchair. Whilst pushing the person we saw only one footplate was used and the persons foot was dragging along the floor placing them at risk of injury.

On Fern unit, we observed the unit lead attempt to assist a person to stand alone. The person was clearly tired and unsteady however the person was clearly encouraged to stand whilst they had been assessed as requiring a full hoist for all transfers. The actions of this unit lead clearly placed the person at significant risk of falling and injury. We spoke with senior management and the manager about our observations. They took immediate disciplinary action toward the staff member involved, and immediately reviewed all people's moving and handling assessments, and ensured the correct equipment was in place. When we returned on the second day we found this had been completed and we observed people being safely transferred using the appropriate equipment. Staff spoken with on the second day were aware of the incident and throughout the second day we observed people being transferred in a safe manner using the appropriate equipment.

Opportunities for lessons to be learned from incidents or near misses were not routinely carried out. Incidents were not consistently documented, investigated or shared with staff in a way that would enable them to learn from the incident, understand what happened and consider other ways to support people in a safer manner. For example, one person had a choking incident 10 day prior to our inspection. This was reported as, "Incident of choking, first aid done successfully, GP informed who advised to cut meat into small pieces and observe swallowing, informing the GP if there are any changes." When we spoke with staff supporting the person with the meals they said they were not aware of the incident and had not talked through this during either handover, meetings or one to one with a senior.

People gave us mixed views about the staffing levels across the home. People on Peach unit were positive about the staffing numbers, and felt that staff were attentive and responsive. One staff member said, "Although we have only thirteen people on the unit it's important we stay at 3 staff as it means we have time for people and can do extra things and spend time with them." One person said, "I don't have a problem summoning staff when I want them, they are the same staff mostly." However, on the other units in the home people's feedback and our observations did not support this positive view. One person's relative told us, "The night staff are not as good as the day staff. [Person] phoned me the other night to say they'd used the buzzer and that nobody had come to help. I called the home but we couldn't get an answer. When we finally did we were told to redial as we'd come through to the wrong unit, so we had to hang up and redial and they were ages answering. This is the big problem, otherwise I can't say anything wrong about the home." However, we were unable to find evidence that supported the persons view that staff did not attend to them when called.

We spoke with the manager and senior management team about the deployment of staff in the home. They

immediately reviewed the leadership on the units and made changes to improve the allocation and support given to staff. They told us they would focus efforts on the dementia unit to review the deployment of staff and train them to be 'Specialists' in providing care to people with dementia and responding promptly to their needs.

Staff had received appropriate training in relation to fire safety, and a recent fire risk assessment had been completed by the local fire service. Issues identified during that assessment had been rectified and the manager was awaiting a visit to sign off the works. Personal evacuation plans (Peep) that instruct staff how to evacuate people, for example by recording what equipment was needed, were generic and not specific to people's individual needs. Staff spoken with had not completed any fire evacuation drills with the people on Peach unit and told us they were not aware of how they would do it. Staff told us they would await the assistance of the local fire service. Delaying the evacuation of people during a fire places people, staff and the fire service at risk of harm. However, we saw from records that fire drills had occurred in the home, and that other staff had completed these. We spoke to the manager who took action to ensure they maintained a log of the shifts when fire drills were carried out and who attended. They had identified that some staff due to working patterns may have never been involved in a fire drill. They also reviewed people's PEEP's and would ensure all staff were aware of what to do in the event of an evacuation.

People's medicines were generally managed well in the home and people received their medicines as required. Medicines that needed to be given at specific times such as pain relief were administered following the prescriber's instruction. We looked at a sample of nine people's Medication Administration Records (MAR). These demonstrated that people had received their medicines as prescribed.

People's medicines were being stored in locked trolleys that were stored securely in the medicines rooms. Staff ensured they monitored daily the temperatures of the trolleys and medicines room to ensure medicines were stored within safe temperature limits. Daily audits of medicines were in place to ensure stocks were accurately maintained, however when we counted the stocks of medicines for nine people we found one tablet was missing for one person.

Where people were unable to communicate verbally to staff that they may be in pain or discomfort, staff completed a sheet that identified when to give people as required medicines. This sheet however did not accurately record how to support people with their pain management. For example, the record noted that people were to be given one or two tablets. There was no guidance to direct staff when to offer one tablet or two, or even to instruct staff to offer one tablet initially and then monitor for improvement. The protocol also did not describe how a person would communicate they are in pain or discomfort. One person's record noted, "For hip pain, general pain and headaches." However, this did not document nonverbal signs the person may exhibit when in pain.

The management team were in the process of moving people's stored medicines from individual units to one central store. They were being supported through this process by the local health authority who were carrying out a number of reviews. Where these reviews had highlighted areas to improve, we saw many of these were in place although some improvements were still required.

Oxygen use in the home was well managed with clear policies about the safe storage and use of oxygen. We saw one person had an oxygen concentrator, although they could manage it themselves they told us staff were always there to assist when they needed it. The relevant risk assessment was clear and informative and staff were aware of maintenance issues such as the need to change the filter each week, ensure the oxygen level was set at one and the oxygen hose was always free from obstacles. One staff said, "I was taught what to do by another staff member."

Requires Improvement

Is the service effective?

Our findings

People spoke highly of the staff. One person said, "The girls always help me and the man is lovely too." A second person said, "The staff do a fantastic job, in what must be very difficult circumstances, with the challenges people must bring. But they seem to know what they are doing or ask if they need help."

Staff observed on Peach were confident in their role and in the support they offered to people. We observed staff helping each other and there was clearly a good working relationship amongst them.

Staff said whilst they received mandatory training, nothing else was offered to them to enable them to develop their skills further, or to have their own specific area of interest. All the staff told us they were committed to learning and that they did want to develop. One staff member said, "Training is not promoted". A second staff member said, "We do the basics, but we need more than just safeguarding and moving and handling. Lots of people have dementia, so we have basic dementia awareness and doll therapy training. It doesn't help with the day to day care these people need." Although we found opportunities for progression were limited at the time of the inspection, the provider informed us that recently a second staff member had achieved a train the trainer certificate which enabled them to train other staff in relation to moving and handling. The provider told us they were committed to developing similar roles in areas such as safeguarding, dementia and health and safety over the following 12 months.

Autumn Vale was working with a local training provider who was supporting them to embed champion pathways into the home. These champions were staff members who received additional training in key areas such as dementia, nutrition, falls, and wound care. Staff then brought back the knowledge to the home and shared this with other staff members in an attempt to improve the quality of care through shared learning. However, care staff had not been given this opportunity. The unit managers completed the training for the majority of the champion roles. When this was brought to the new manager`s attention, they approached a staff member who demonstrated a clear passion and understanding of people living with dementia. When they asked whether they would like to take on the role of 'Dementia Champion' the staff member was clearly excited by the opportunity. The new manager told us they would review the training provision and look for opportunities for staff to further develop in their role.

Staff told us they received regular supervision. They told us they were able to discuss areas such as their performance, any difficulties they were facing, and discuss any observations of their practise that had been carried out. One staff member said, "Supervision is regular and I like it. It's good to talk through how I am and if I need anything and also to get feedback." However, staff also told us they did not feel supported by senior management due to the recent management changes. One staff member said, "My supervision is fine, I feel that [line manager] is there when I need them, but above them, no I don't feel there is support for me from the top."

Staff asked people for their consent to care before they carried out any tasks. For example, we heard staff asking people if they were ready to get up in the morning or if they wanted to stay in their rooms or sit in the lounge. Staff clearly explained the task they needed to do and waited for the person to respond. If needed,

staff then clarified their request and respected people's views if they did not wish to give consent. For example, one person was in their bed and we heard staff talk to them about getting washed and ready for the day. The person had difficulty understanding what was said and staff clarified what they needed to do. Once the person understood, they said they did not want to get up and when they did would let staff know. We spoke to this person who told us, "They are lovely really, very accommodating and will only help when I say they can."

However, where staff recorded consent in people's care records we found this was not always acted upon. For example, we saw one person had informed staff when they completed the 'Residents choice form' that they did not wish to be resuscitated. This person had the capacity to make this decision and this was recorded appropriately. However, staff had not then completed the appropriate form, therefore not acting upon this person's legal choice and consent they were placing them at risk of being resuscitated. We asked the manager to ensure all decision relating to resuscitation were clearly documented and appropriate consent obtained and acted upon. When we returned on the second day of inspection this had been done, although routine consent forms for areas such as use of photographs, care plans or treatment were not consistently signed by either people living in the home or their legally appointed representative.

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 mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that staff were knowledgeable about the principles of the MCA and the need of best interest decisions to ensure the care people received was in their best interest. However, we also found examples where an MCA had not been completed for certain decisions, for example when administering medicines to a person covertly. We also found that MCA's had been completed when there was no requirement to do so, for example where a person had appointed a lasting power of attorney to manage their affairs.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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. We found that DoLs authorisations had not been submitted for those people who had their medicines administered covertly. We spoke with the manager who reviewed all people who may require an authorisation and when we returned on the second day of the inspection found the manager had submitted a further four authorisations previously not completed. These were for covert medicines, use of bed rails and leaving the building.

Dining rooms were laid out for lunch with condiments, table cloths, napkins and drinks available and appeared welcoming. We observed a sociable atmosphere with people talking among themselves or with staff.

However, we also observed that people living with dementia were not aware of what lunch was for that day until it was presented to them. Staff used menus with photographs that depicted each day's meal choices which were placed on the dining tables, however none were for shepherd's pie, which was the lunch choice for that day. Staff did not seek to offer people a choice and plated up their meals without asking what people wanted. The choice of food given to people was not always appealing, for example on the first day of our inspection people were seen to be offered shepherd's pie, served alongside rice, potatoes and vegetables.

There was a list of people's dietary requirements and allergies available to staff and we saw these were followed. People were supported to remain as independent as possible when eating their meals by using specialist equipment such as plate guards, two handed beakers and adapted cutlery.

We saw for those people who required their meals to be pureed, this was ladled into a small bowl which left the food merging together and appearing particularly unpleasant. We heard one person tell staff they were not eating that, and another person was observed to only eat two or three small mouthfuls. We discussed this with the senior management team and manager. They told us they had identified that the kitchen staff required further support and development and had enrolled them on relevant training in these areas. They also told us they had ordered food moulds that would make the meal appeal more palatable.

People had access to health and social care professionals as needed. One person told us, "If I want to see a doctor I just need ask and they put me on the list, the other week they sorted out the chiropodist for me." A second person said, "I am very confident that if I needed someone like that [health professional] then they would arrange it." We saw evidence that people in the home had been supported by GP's, district nurses, dieticians, chiropodists and mental health specialists among other professionals.

Arrangements were not always in place to ensure people had access to the communal grounds and gardens. The grounds around the home were poorly maintained with grass having grown to a significant length and bushes growing to the point it impeded people's views from their rooms. The rear communal gardens did not allow safe access to people and their visitors as they had not been maintained and paths and patio areas were not safely accessible due to fallen branches, weed growth and poorly maintained hard landscaping areas. We observed one person and their relative attempting to access the communal space outside Fern unit, but had to give up as they were unable to walk safely whilst pushing the wheelchair.

Although the environment in the home was clean and well presented, the decoration of the home did little to support people living with dementia. There was a distinct lack of items for people with dementia to use such as items for reminiscence, clothing, themed areas or tactile areas. In the lounge the only 'sensory' item being used was one very small bubble lamp in the corner which was ignored by those present. The communal garden in the dementia unit, although laid out so people could engage with growing plants and vegetables was not used and had not been maintained to ensure people could pursue interests and hobbies. The provider told us they were in a process of consulting with people to understand better what people felt was important to them before making changes to the home. During the inspection they organised an external gardening company to start tidying the grounds to ensure people could fully use the facilities. This was an area in need of improvement.

Good

Is the service caring?

Our findings

People spoke positively about the staff and told us how kind and respectful they were. One person told us, "They know us well and treat us very good indeed." A second person said, "I significantly lost my mobility last year and the staff here have been first class, very responsive, and very careful when they help me, I think they are a very caring team here."

Staff were clear about how they treated people in a respectful and dignified manner. They described to us in depth how they provided personal care in a way that gave people privacy and ensured their dignity at all times. We saw people were dressed appropriately. We noted when one person spilled food on their clothing they were discreetly supported to get changed. One staff member told us, "I spend longer with these people than I do with my own family, so for us, they are our family and we treat them the same way." A second staff member said, "I have to make sure that I am always aware of how my actions impact on the resident, what their own preferences or choices are and their life experiences. What is acceptable to one person is not to another. I try to help people live a dignified life by meeting each of those areas."

We observed staff knocked on people's doors and waited to be invited in before entering. Staff were discreet when people required assistance to leave communal areas to use the toilet or change their clothes. One person was becoming quite agitated that they wanted to use the bathroom, however we saw a staff member approach the person calmly, speak softly into their ear, and take them by the hand as they walked with them to the bathroom. The person later re-joined others in the lounge in a calm manner and continued to enjoy what they had been previously doing. Staff had time to walk with people along the corridor and we saw positive interactions between people and staff members. We observed a person agitated and tearful on Fern unit. A staff member went to find some photos from the person`s bedroom and brought them back to the lounge and sat with the person looking and reminiscing about the people in the pictures. The person was seen to visibly calm and relax as they shared jokes and smiles with the staff member.

People were asked about their preferences regarding having the care provided by either male or female staff, and this was adhered to. However, staff understanding of religion, culture and sexuality needed to be further improved as this was not an area routinely explored either at assessment or through care reviews. For example, one assessment noted, "[Person] is a catholic so has no cultural or sexuality beliefs at present." Staff had not attempted to explore how to support the person`s religious or cultural needs based upon their religious beliefs. We found numerous examples where this was present. We discussed this with the manager who told us they were redeveloping people's care plans as part of a 'Who am I' initiative where they believed people's individual needs would be further explored.

People's care records were stored in the nurse's stations and kept locked. Where information was held on the units or in people's bedrooms this was done securely. Staff were aware of the need to speak at a low level when discussing people's needs to maintain their confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt their needs were responded to promptly and that staff knew how to provide care to them that met their individual needs. One person said, "They know what I like and how I like it. Although they use a lot of temporary staff at night, there is usually one of the regular ones around so the care is pretty consistent."

We found that the knowledge staff had of people was sufficient to meet their needs. For example, those people who required regular repositioning received this as required and where those people had developed pressure ulcers these were healing well. People's requests for support were promptly responded to and people's personal care needs were met in a manner that people preferred. However, people's care records did not provide clear guidance to staff to provide care that met people`s needs. Care plans we reviewed were task focused and failed to give staff the essence of the person and how they wished to be supported. Care plans contained tick box entries and pre- populated text fields which meant that staff selected the area of support people required help with but did not then further explore the persons individual preferences or directions regarding the care they received. For example, one care plan stated, "[Person] requires all help with personal care." Staff had not explored with the person how to assist them or how the person liked to be helped.

People told us they had not been involved in reviews of their care and care plans we looked at demonstrated this. Care plans had numerous sections covering a range of needs, such as personal care, nutrition, mobility and skin integrity. Each section had been reviewed each month, however there was no evidence to suggest people had been involved and staff had repeated the wording used for each month. For example, one person required assistance with their personal care. The reviews of the persons care needs were repeatedly reviewed as, [Person] still requires the help of one to two staff to assist with all personal care. [Person] should be encouraged to take a shower when needed." However, when discussed with this person they told us they needed minimal assistance from one staff member, and that they did not like showers and preferred to take baths. This meant the reviews of people's care were not focused on their preferences or needs, and did not involve people in decisions about how they received their care.

People spoken with gave mixed views about how staff support them to engage with meaningful activities. Staff told us about the activities provided in the home. One person told us, "There are things to do if you really want to. When there are activities it's good." A second person told us, "I just sit here in my room all day, I don't want to be a bother to anybody. There's nobody in the lounge that I can have a chat with, and I don't see my family very much, so I just sit here, nothing to do. I would love to go into town and buy some clothes, but my [relative] doesn't help me, and nobody from here can go with me."

Where people were less reliant upon staff to support them, we found they were able to pursue their own interests. One person showed us a collection of camera's they had collected as part of their hobby. They told us they were able to leave the home when they pleased and enjoyed days out with friends actively pursuing their interests.

Staff spoken with told us they tried to support people to the best of their ability, but found it difficult to access the community with people. One staff member said, "We don't have a minibus or any transport, we used to take people out more, I would like to take residents out for a day trip at the seaside as I know they'd love that but we don't have transport." This further meant that other group outings could not be planned due to a lack of transport meaning people were not able to access the local community.

Our observations through the inspection of staff supporting people with meaningful activities were varied. For example, of the first day we saw the communal lounge on Fern unit was dominated by one person who watched the same film over and over again which was also playing loudly all day. A staff member told us they did this as it kept the person calm. However, all the other people in the lounge could neither watch the TV or listen to music as the TV was playing so loudly. On the second day of the inspection we saw staff were engaged with people in the lounge playing board games, listening to music and gathered in small social groups talking and laughing.

We observed staff encourage a person to pick up a broom and give the lounge floor a sweep, the person looked visibly content having a meaningful job to do and staff told us it was a job they had given them in addition to collecting plates once people had finished their meal. However, this approach was not consistent across the home. A person on a different unit told us they loved cleaning and doing things around the home, but now they weren't doing any domestic tasks they enjoyed. Although this person had reduced mobility they could have been engaged in a meaningful way with chores they enjoyed that was within their capability. However, for this person staff had not sought to find manageable tasks for them to complete.

There was not a consistent opportunity for people's views and opinions to be heard by management. People told us they had not attended a meeting within the home to discuss developments, improvements or changes. People's relatives also told us there had not been an opportunity for them to provide their views about the care their relative received. One person said, "There used to be a meeting in the lounge, they were quite good but there hasn't been one for a good while now." The manager told us that they were introducing themselves to people and relatives and as part of this would be introducing resident and relative meetings.

People and relatives were not all confident that if they raised a complaint or concern it would be acted upon. One person said, "The staff on here are on any gripe or grumble in a flash, I am happy they would resolve a complaint." However, one person's relative said, "To raise a complaint firstly I would need to know who the current manager is. I can't bring things to their [management] attention because I don't believe they will be here long enough to resolve it so we tend to say nothing." However, where complaints had been raised these had been responded to appropriately and within an acceptable time period.

Requires Improvement

Is the service well-led?

Our findings

The provider demonstrated a clear approach to providing people with person centred care that was underpinned by a staff approach that put people at the centre of what they did. However, people, relatives and staff gave a mixed view on the leadership and management of Autumn Vale Care Centre. One person said, "I've met the new manager, they seem very energetic and enthusiastic, hopefully they will be the one who gets things going again." However, a second person said, "I think another manager has started, I don't know who they are but it seems as if they are always changing."

Staff were positive about the appointment of the new manager, with one staff member telling us, "[Manager] has hit the floor running, they want our ideas and they want to bring in changes that will mean something and not just be quick fixes." However, a second staff member said, "We've seen lots of managers come and go, nobody stays, there's no support from head office." All the staff spoken with told us that staff morale was low which they attributed to constant management changes. Since Autumn Vale Care Centre registered in May 2017 there had been three managers employed. The provider had put an interim manager in the home to provide day to day support, along with an increased presence by senior management in the home. However, people and staff spoken with told us that their view was that management would once again change so felt disconnected from the service and worked within their own smaller teams, as opposed to being part of one big team across the service.

Staff spoken with told us that they had monthly meetings however they also told us they did not feel these were valuable due to the changes and lack of consistency with management. Staff told us that when they attended a meeting they felt it was a forum for management to tell them only where they needed to improve. One staff member said, "The team meetings are not about the residents or for us to bring our own ideas, we get told off and told we need to do this or that by this time. It doesn't help with the morale or make us want to go the extra mile when we just get moaned at."

The provider had systems in place to monitor the quality of care provided to people. We saw that regular visits were undertaken by senior management where areas such as staffing levels, safeguarding, training, falls, infection control and care records were audited. These reviews of the service had led to the provider taking the decision to close one unit in the home so they could review the care they provided. The provider had looked at the staffing levels in the home, agency usage, and skills mix and determined that due to the significant needs of people being referred from hospital, they needed time to review and develop their work force further. This was a positive step as the provider had identified through their own monitoring that people may not have received care that was of a sufficiently good level.

In addition, the provider had commissioned an independent consultant to review the quality of care and provide a report of their findings. However, we found that issues identified in these audits were not consistently addressed. For example, in March 2018, the auditor had identified that leadership on Fern unit was an area of concern. They also found that people on Poppy unit lived with significant dementia and would benefit from increased one to one time. Neither issue had been acted upon until we showed the newly appointed manager during the inspection how the lack of effective leadership across both units had

led to care that required improvement. In addition, our inspection identified additional areas that had not been picked up through the providers governance systems, for example issues around DoLS not submitted, care plans not completed, and lack of activities.

We talked to the provider about the challenges they faced with recruitment, and although the reliance upon agency staff had reduced, there were still a number of unfulfilled staff vacancies, of which most were at night. This issue had been ongoing prior to the re-registration of the service in May 2017, and little in terms of addressing the vacancies had been achieved. The provider had recently increased staff pay in an attempt to attract new staff to work at Autumn Vale, however practical steps to address the difficulties staff had in reaching the home due to its isolated location had not been addressed. However, the provider had recently appointed specialist recruiters to continue to address this issue. These staff were working on initiatives which included contacting a local coach and taxi company to agree preferential rates to bring staff into the home, in addition to a bonus payment for existing staff who introduce new staff to the home.

Throughout this inspection we identified and reported to the manager and provider areas that required improvement as demonstrated throughout this report. Although the manager took swift action to make improvements and mitigate the risks to people's health and wellbeing, these areas were identified by CQC and not through effective monitoring by the management team. This is an area that requires improvement to ensure the management team use the tool available to them to identify where improvements are needed and to take effective action.

People's care records were not accurately maintained as they did not provide staff with sufficient instruction in how to provide care to people. Where care records were completed they referenced the care required, for example transferring from bed to chair, but did not provide staff with clear guidance in how to carry out this task. Although this risk was mitigated because staff demonstrated an awareness of people's needs we did observe on three separate occasions people being assisted with transfers in a manner not consistent with the care plan.

Notifications of significant events were submitted to CQC in a timely manner, and the managers in post at the time of these events responded quickly to ensure actions were undertaken to minimise the risk of harm to people.