Tower Bridge Homes Care Limited

Tower Bridge Homes Care Limited - Sycamore

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

Summary of findings

Overall summary

We previously carried out an unannounced comprehensive inspection in February 2017 at which time the service was rated as requires improvement and three separate breaches of the legal requirements were found. These related to the safe management of risk, medicine management, unsafe environment, ineffective systems and processes to monitor quality and safety and insufficient staffing levels. Other areas that required improvement included training and support for staff, compliance with DoLS legislation, treating people with dignity and respect, keeping people's confidential information secure, seeking feedback from people and improving activities and social interaction for people and ensuring a 'dementia-friendly' environment.

Following that inspection the provider sent us an action plan, which set out what they would do to meet the legal requirements in relation to the breaches and to improve the service.

We re-inspected the service in October 2017 to check that the necessary improvements had been made. At this inspection we found that whilst there had been some improvement in certain areas, there were still issues of concern and continued breaches of the regulations and the rating remains 'Requires Improvement'.

This inspection took place on 29 and 30 October 2017 and was unannounced. During the inspection we found breaches of Regulation 9, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of our concerns we sent the provider an urgent action letter asking them to submit an action plan to set out how they would deal with the issues we found. We then completed a further inspection visit on 22 November 2017 to check their progress.

Sycamore Court is a residential care home registered to provide care and accommodation for 39 older people. There were 35 people living in the service at the time of our inspection. The service was spread across two floors. Upstairs accommodated people with more complex needs related to living with dementia.

There had been a significantly high turnover of managers over several years and this had impacted on the quality, safety and effectiveness of the service. Instability in terms of leadership and a lack of oversight by the provider meant that many of the issues we found during our previous inspection had still not been addressed. There were quality assurance mechanisms in place to measure and improve the quality and safety of the service but these had been ineffective as they had failed to address many of the issues we found.

At our previous inspection a new manager had only recently been appointed and was going through the registration process. However before the process was completed they resigned from the company. We were subsequently notified that the provider had recruited a new manager who has since become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The new registered manager had a positive impact on the service and was viewed by people and staff as approachable, accessible and supportive. The registered manager took a 'hands-on' approach and any concerns or complaints were listened to and dealt with appropriately. However, due to insufficient support from the provider the registered manager lacked the resources to make all of the required improvements.

The service was struggling to recruit new staff so was using a high percentage of agency staff. This impacted on staffing numbers, deployment of staff and skill mix and meant that people's needs were not always met safely and effectively in a way that reflected their preferences. People's experience of being cared for varied considerably depending on which staff was providing the care and support and people did not always feel as if staff knew them well. The high percentage of agency staff used meant that some staff working at the service did not have the knowledge and experience of people to support them effectively.

We made a recommendation that the provider review their system for inducting, supporting and overseeing agency staff.

People had risk assessments in place which were regularly reviewed. However in some instances, specific risks to people had not been identified, assessed and recorded.

During our first two visits we saw that some areas of the service posed a risk to people due to environmental hazards. The registered manager addressed our concerns immediately and at our third visit we found the environment had been made safe.

People's care needs had been assessed and regularly reviewed. However, improvements were required to ensure all people or their representatives were fully included in the process.

The care provided to people was task-focussed rather than person-centred due to time constraints and staffs lack of familiarity and knowledge about people's needs. People's routines and preferences had not always been explored, documented and upheld which meant choice was not always supported.

People and relatives expressed mixed views regarding available opportunities to engage in activities and social interaction. Our observations throughout the inspection showed that there was very little stimulation available for people.

We made a recommendation that the provider review their activities programme.

People's ability to make decisions had not been consistently assessed in line with the Mental Capacity Act, 2005 (MCA) and applications for Deprivation of Liberty Safeguards (DoLS) had not always been completed. However, at our third visit we found that the registered manager had addressed our concerns and the service was now meeting the requirements of the MCA and DoLs legislation.

The service supported people to have enough to eat and drink although this had not always been accurately recorded to effectively monitor people's nutritional and hydration intake. People's comments regarding the quality of the food was mixed.

The provider responded positively to our concerns, submitting an action plan which was detailed and

robust and demonstrated a commitment to improving the quality of care. The provider had commissioned a specialist consultancy to work alongside the registered manager and staff team to support them to drive improvements. On our third visit we saw evidence of actions already taken to address all of the concerns outlined above but it was too soon to measure the impact of the new ways of working.

Staff had received training and regular supervision to support them to be competent in their role. This included training in how to safeguard people from abuse. Staff knew the signs to look for and how to report their concerns. Staff were aware of the whistle-blowing policy and said they would feel confident to speak up if necessary to keep people safe.

There were systems in place to ensure the appropriate management of medicines and people received their medicines safely. Recruitment processes were also robust and staff were recruited safely.

The service had formed positive working relationships with healthcare professionals to support people to remain healthy. However, some people felt that improvements were required to ensure they received treatment in a timely manner.

Staff were kind and caring though did not always have time for sustained interaction with people. People were supported to be independent and maintain relationships with people who mattered to them. Relatives and visitors were made welcome at the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Deployment and skill mix of staff was insufficient to provide care and support that safely met their needs and reflected their preferences.

Specific risks to people had not always been identified and assessed.

Medicines were managed safely.

Safe recruitment processes were adhered to.

Is the service effective?

Requires Improvement

The service was not consistently effective.

High usage of staff unfamiliar with people's needs impacted on the effectiveness of care and support provided.

Oversight of temporary staff was not robust to ensure they had the skills and experience to support people effectively.

The service provided training, supervision and appraisals to support permanent staff to be competent in their role.

People were supported to have enough to drink though there were mixed views about the quality of food.

Staff understood the importance of obtaining consent.

The service supported people to have access to healthcare however, some people expressed dissatisfaction with delays in obtaining treatment.

Is the service caring?

Requires Improvement

The service was not always caring

Staff were kind and caring but did not always know people well

and have time to spend with them.

People were supported to be independent.

The service welcomed visitors and helped people maintain important relationships.

Consideration was given to people's wishes for end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Inconsistencies in the staff team meant that people's needs and preferences were not always known and upheld.

The home environment was not 'dementia friendly' and there was a lack of opportunities for stimulation, social interaction and engagement.

People and relatives knew who the manager was and felt confident to make a complaint and that it would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of consistent and stable oversight and leadership of the service at manager and provider level.

Quality assurance mechanisms were in place but had not been effective in picking up on the issues we found.

The new registered manager was viewed positively by people, relatives and staff which had improved morale.

The provider responded pro-actively to our concerns and support mechanisms had been put in place to drive improvement.

Tower Bridge Homes Care Limited - Sycamore

Detailed findings

Background to this inspection

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

The inspection which took place on 29 and 30 October and 22 November 2017 was undertaken by two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed all the information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We also reviewed information received from relatives of people who used the service and information shared with us by the safeguarding and quality improvement teams of the local authority.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Over the course of our inspection visits we spoke with the registered manager and nine staff. We also spoke with nine people who used the service and eight relatives. We reviewed various documents including people's care records, staff files and other relevant documentation such as training records, quality audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2017 we found a breach of Regulation 18 of the Health & Social Care Act due to insufficient staffing to meet people's needs. At this inspection we continued to have concerns about whether there were sufficient numbers of skilled staff who had been effectively deployed to meet people's needs. We had received information of concern from relatives of people who used the service that this was an issue particularly at evenings and weekends. We therefore carried out a weekend inspection which took place over the afternoon and evening. We arrived at 4.30pm on a Sunday afternoon and found that on the first floor, which accommodated people living with dementia, twelve people were already in bed. This floor should have been allocated three staff and one senior but one member of staff had not turned up and the service had not been able to arrange cover. Staff told us that people living on this floor had very high needs and were supported for bed rest after lunch. When we asked why they were still in bed we were told that they did not have sufficient staff to get people up again. One staff member said, "People are left in bed due to lack of staff; some people like a day in bed but I agree as we were short today we have not got people up." The specific risks to people who spent protracted periods of time in bed, either through choice or due to low staffing levels had not been thoroughly assessed and there was no clear management plan in place to ensure their safety and wellbeing. For example, the service had not considered whether people were able to use their call bells to ring for assistance and there was a lack of guidance for staff regarding the checks that would need to be in place if people could not call for help.

We found that there were issues around staff deployment and staff skill mix and this impacted on the quality and safety of the care people received. Due to significant difficulties with staff recruitment the service relied heavily on agency staff usage. One staff member told us, "There has been nights when it has been all agency staff working." We looked at the staff rotas which confirmed this was sometimes the case. Whilst the service tried to secure regular agency staff this was not always possible. This meant that sometimes people were supported by some agency staff who were unfamiliar with the service and the people who used it. A staff member said, "Some days are hard, if last minute we get strange agency staff who don't know the service or people, it can be more difficult then."

All of the staff we spoke with told us that issues with staffing were made worse by the high level of agency staff use. Staff comments included; "I love it here but staffing issues are massive. I dread coming in sometimes when it is all agency staff; we have a few regular ones that come and they are good." And, "We very rarely have permanent staff, mainly agency staff and it can be challenging." And, "I sit and cry sometimes worrying about people. I know [registered manager] is trying to sort things and reassess residents as dependency up here is very high."

We received mixed views from people and relatives regarding staffing levels with some people and relatives reporting that they waited a long time for call bells to be answered, particularly in the evenings or at the weekends. One relative told us, "They do not always answer the call bell quickly but they are so busy, more so of a weekend." A person said, "I do feel safe here but the only thing is you do have to wait often of an evening for the call bell to be answered and when they come the favourite saying is 'I will be back in a minute, it is often a long minute." Another person said, "Often of a weekend there are not enough staff on

duty so the others are rushing around trying to look after us." Two people told us that they felt there was enough staff to keep them safe. One person told us, "I feel very safe here, the other day I had a fall and buzzed and within two seconds two members of staff came to help me." Another said, "Although the staff are very busy they will usually come when you call them." During our first two visits we observed that staff worked hard to meet people's needs and answer call bells in a timely fashion but there was little time for sustained interaction. People were left unsupervised for extended lengths of time in communal areas with no means of calling for assistance. A person sitting in a communal area explained they were unable to get up without support. We asked how they would call for support and they told us they would just have to wait until a member of staff came in to the room.

We spoke with the new registered manager about our concerns regarding staffing levels, skill mix and deployment. They advised us that since joining the service they had taken various actions such as increasing the staffing levels by one member of staff on each floor. However, there were times when the service was not able to secure any cover for last minute staff absence which would leave them short-staffed. Furthermore, where it had been identified that people had high or complex needs which the service could not continue to safely meet, the registered manager had served notice to end people's placements. We also saw evidence that the registered manager had been pro-active in trying to recruit permanent staff, for example, through holding regular open days. The open days had not been particularly successful due to the rural location of the service. The registered manager also told us that they were currently exploring the possibility of purchasing a vehicle to ferry staff from bus stops and the train station to counteract their recruitment difficulties.

This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to the significance of our concerns we wrote to the provider asking them to provide us with an urgent action plan to set out how they would address the issues around staff deployment and skill mix. We subsequently completed a third inspection visit to check whether any of the improvements outlined in the action plan had been implemented. The registered manager advised us that they were completing an on going piece of work assessing the dependency levels of people to ensure the correct staff ratios. We saw that risk assessments had been completed for people who spent long periods of time in bed and management plans were in place to monitor their health and safety. Discussions had taken place with the recruitment agencies used to ensure that the service was only provided with regular agency staff who were familiar with the service and the people who used it. The registered manager had been provided with an increased level of support from the provider with their recruitment drive to attract new staff. We were advised that five new staff had already been recruited. In addition, greater consideration of the skill mix of staff was being given to ensure that moving forward agency staff always worked alongside permanent staff. We also saw that the service had introduced a new staff allocation sheet which provided additional guidance and direction for staff to ensure they were deployed effectively. We spoke to two senior members of staff on shift that day. They confirmed that deployment of staff had improved with the registered manager ensuring there were permanent staff on both floors and that they only used regular agency staff.

At the previous inspection we found environmental hazards which posed a risk to people's safety. At this inspection we saw that whilst some of these hazards had been remedied, there were still issues with environmental safety. The service was not storing people's prescribed creams in a safe way. We saw that some people had creams for their skin left out on bedside cabinets in their rooms. The risks around this had not been assessed, for example, risks to people living with dementia who may over use creams or potentially swallow them. We also found that some people's wardrobes were not secured to the wall and the kitchen door upstairs was unlocked with no staff supervising the area. This meant that vulnerable people could

enter the kitchen. We found cleaning liquids stored in an unlocked cupboard and the radiator in the kitchen was hanging off the wall, leaving sharp edges exposed.

We shared our concerns with the registered manager who later provided us with evidence that the issues had been addressed. At our third visit to the service we checked the environment and saw that the necessary action had been taken to ensure people's safety.

At our previous inspection we found that risks related to people's hydration were not well managed. Fluid charts were kept to monitor people at risk of dehydration but the amounts were only recorded until 5pm each day so did not represent an accurate picture of what people had drank. At this inspection we found the same recording practices were still in place. We also found that charts which recorded when people had been repositioned were also not consistently completed, particularly at night-time. This meant that staff were unable to demonstrate that they had supported people with their pressure care and assisted people to remain hydrated to keep them safe and healthy.

We highlighted our concerns in the urgent action letter we sent to the provider. At our third inspection visit we found a new style fluid chart was in place which was being used to record the amounts people drank over a 24 hour period. We also saw greater consistency in recording when people had been repositioned at night. We checked four people's fluid records and found the necessary improvements had been made in recording practices and good targets for fluid intake for people at risk of dehydration had been achieved. However, we found that further improvements were still required in terms of fully completing the form to record whether targets were met or whether further action was required. In addition when we looked at people's food charts we saw that these did not record when people were being given food supplements so were not an accurate representation of people's nutritional intake. Staff advised us that they were still getting used to the new paperwork.

We recommend that the provider work with staff to promote understanding and awareness of any new systems and processes to ensure the safety and quality of the service.

At our previous inspection we reported that improvements were required in how medicines were managed. During this inspection we found that the necessary actions had been taken and people's medicines were managed safely. Medicines were stored securely and at the correct temperatures which were checked daily. The medicine trolley was kept secure and the contents of the trolley were well ordered and clean. People had individual medicines administration records (MAR) which showed their photograph so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving the wrong medicines. We saw that there were no gaps on people's MAR sheets indicating that people had received their medicines as prescribed. Protocols had been put in place to provide additional guidance to tell staff when each person should receive medicines that had been prescribed on an 'as needed' basis to ensure people's needs were met safely and effectively. We found that records relating to stock control of people's boxed medicines did not always tally up. However, when we discussed this with the registered manager they were able to identify and account for any discrepancies.

We observed a senior member of staff completing the medication round. The medicine trolley was taken from room to room. The staff member was competent administering people's medicines and talked to people affectionately, engaging them in conversation to put them at ease. Water was provided to support people to take their medicines. We did note that on two occasions the senior had to stop administering medicines and lock the trolley to respond to people that were requesting help. This the senior did without hesitation. The senior asked one person if they would prefer them to come back when the person had a cup of tea, as they knew the person preferred to take their medicines with their tea. The person told the senior

they did want them to come back a bit later. This showed that the senior was aware of people's preferences about how they liked to take their medicines.

We looked at people's care records and found that there were risk assessments in place which were linked to people's individual care plans which covered aspects such as mobility, medication and skin care. These assessments identified any hazards that needed to be taken into account and gave staff guidance on the actions to take to minimise risk of harm. For example, in one person's care plan it detailed the size and colour of the sling that needed to be used to support the person to be hoisted safely. We saw that these risk assessments were kept under review and updated as peoples' needs had changed.

Where people had catheters in place, the risks associated with this were also well managed. The service kept a folder which recorded weekly catheter checks. Staff kept a log which showed when people's catheter bags were changed and if staff tested people's urine for infection. Where these tests showed a positive result we saw that the information was shared with the GP so that people could be prescribed antibiotics.

We spoke with staff to check their knowledge and understanding of risk. The regular staff we spoke with demonstrated a good awareness of the risks to people and how to prevent or minimise them. However, feedback we received from people and their relatives indicated that temporary agency workers did not have the same level of knowledge and understanding of people's needs. Comments from people included; "There is not enough staff, the permanent staff are good but there are too many agency staff that do not know people living here well enough." And, "Agency staff come and go, half don't seem worried about people; The permanent staff run the home and are very good; [Senior] works very hard but there is not enough staff, they are always short." And, "Staffing is totally inadequate, permanent staff do try but things are missed, I come every day as I do not think my [family member] is always safe."

We asked agency staff how the service shared information with them regarding people's care needs and any risks and how to manage them to keep people safe. They told us that they received a verbal hand-over when they came on shift.

We discussed our concerns regarding how the service supported agency staff to gain the necessary knowledge and understanding of people's needs with the registered manager. The action plan we were subsequently provided with demonstrated that the provider recognised that improvements were required to ensure that all staff who worked at the service had sufficient guidance on people's needs and the risks to each individual in order to keep them safe. At our third inspection visit we saw that they had introduced a new hand-over sheet which provided much more detailed information on each person. This was shared with staff when they came on shift. In addition the management team had designed a care plan summary to go in the front of people's care records. This provided a pen portrait of each person highlighting important information on people's needs and risks staff needed to be aware of when supporting them.

Staff we spoke with demonstrated a good understanding of how to protect people from the risk of abuse. Staff were able to describe the signs of abuse and the procedures to report any concerns they might have about people's wellbeing. We saw that the registered manager recorded and dealt with any safeguarding issues appropriately, including notifying us of incidents promptly.

Safe recruitment practices were adhered to. All of the relevant checks had been completed including taking up satisfactory references, obtaining a full employment history and carrying out checks to ensure staff were not prohibited from working with vulnerable adults.

Accidents and incidents were recorded and analysed. We saw the registered manager completed a monthly

falls audit which monitored when people fell and described the action taken. We saw that the registered manager had taken action such as making referrals to falls prevention, requesting medicine reviews, increasing staffing numbers and requesting social work reviews to try to minimise the risks to people.

A range of health and safety checks were routinely completed, such as inspections of the passenger lift, electrical and gas appliances. Certificates and records were maintained of these checks. There were arrangements in place to deal with foreseeable emergencies. Personal Emergency Evacuation Plans (PEEPS) were kept on file with copies available at the entrance to the home to guide staff on the safest way to evacuate people in an emergency situation.

Requires Improvement

Is the service effective?

Our findings

People were positive about the skills and abilities of the regular staff who worked at the service. One person told us, "The permanent staff are all very willing and capable." Another said, "The regular staff are wonderful, they really know what they are doing." However, due to recruitment difficulties the service was forced to rely very heavily on agency staff and people told us that this impacted on the effectiveness of the service they received. One person told us, "I suppose they know what they are doing but there are a lot of agency staff so they just do what they have to." Another person said, "The agency staff do not always know what they have to do for you, how would they if they are different ones a lot of the time." Staff also felt the impact of high usage of agency staff on their ability to provide an effective service. One staff member told us, "If there are three permanent members of staff on duty it runs like clockwork here, and we can give the residents who require a higher level of care more; however like today there are three agency on with me so rather than keep telling them what to do I do it myself."

We saw that the registered manager completed observations and competency checks on permanent staff to ensure they had the skills and knowledge to support people effectively. However, these checks did not extend to agency staff. The service held copies of agency staff profiles on file which detailed their qualifications and training. However, observations to assess whether agency staff were competent in putting this training into practice at the service were not completed and recorded. This omission meant that the competencies of agency staff were not measured and thus the provider could not be sure agency staff had the skills and knowledge required to meet the specific needs of the people using the service.

We discussed our concerns regarding the lack of oversight of agency staff with the registered manager. They told us that they were hands-on, often working out on the floor working and would therefore informally observe and assess agency staff on a daily basis but this was not recorded. We did note that senior and permanent staff tried to monitor the competency of agency staff on their shift, overseeing them when possible and informing them what people that used the service required. However, they told us that these additional responsibilities often made their own job more difficult.

We spoke with agency staff about their induction into the service. They told us it included being provided with information regarding fire safety and first aid plus being given a verbal hand-over regarding the care needs of people who used the service.

We recommend that the provider review their current systems and processes for induction, support and oversight of agency staff to ensure they have the necessary skills, knowledge and experience to provide effective support to people.

When new staff joined the service they received an induction to support them to get to know people. One staff member told us, "I had an induction day on my first day that included training; I then had three shadow shifts; I did my medication on line but then the manager showed me the medication system here before I started administering medication." For staff that were new to care the induction included completing the care certificate. The Care Certificate represents a set of standards that health and social care workers should

understand and apply in their daily working life. An excellent feature of the service was the commitment the registered manager demonstrated to following best practice principles when using the Care Certificate as a means of inducting staff. Staff were required to complete a workbook which they brought with them to supervision sessions so that the registered manager could effectively monitor their knowledge and skills.

Training, supervisions and appraisals were provided to staff to support them in their role. The registered manager kept a record of staff training to ensure it was up to date. We reviewed the training records and saw that most training was up to date, the majority of which was completed though an E-Learning training system. Supervision and appraisals are a means of supporting staff with their learning and development and providing support. We saw that staff received one to one supervision four times a year which included an annual appraisal. Staff confirmed supervisions had taken place and told us they were a useful tool to aid their development and explore any concerns.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We found that staff had received training in the MCA and understood the importance of gaining consent from people before providing care and support. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. Care files we viewed contained mental capacity assessments, which highlighted the person's ability to make particular decisions. We saw that these had been completed by staff and evidenced consultation with the person and their representative. However, we found cases where people's ability to make particular decisions had not been assessed, for example, with regard to people's choice to remain in bed.

We outlined our concerns regarding consideration of mental capacity in the urgent action letter we sent to the provider. During our third inspection visit we saw evidence of completed MCA assessments and best interest decisions made in respect of people's choice around spending long periods of time in bed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that the registered manager had submitted applications for DoLS authorisations for the majority people where required. However, we identified five cases where a DoLS authorisation had not yet been applied for.

We discussed our findings with the registered manager who subsequently provided us with written evidence that all DoLS applications had now been completed and submitted for all people that needed one.

The service supported people to have enough to eat and drink. We saw that people had access to hot and cold drinks throughout the day which were within reach. Some people's food and fluid intake was being monitored because they were at risk of losing weight or dehydration. Whilst the recording of food and fluids historically finished at 5pm night staff told us that in practice people were being provided with food and fluid throughout the day and night. One night staff member told us, "The staff handover to let me know if people have not eaten and drank much, then we check if people are hungry and offer fluids through the night."

Feedback from people regarding the quality of the food was mixed. The main criticisms related to the use of agency chefs. Comments included; "The food here is quite good, but we do not have a regular cook all

different ones." And, "I'm not keen on the food but we do not have a regular cook here now and there's not much fresh veg." And, "The food is overcooked here." However other people and relatives were complimentary about the food. One person said, "I am finicky but I am happy with the food." A relative told us, "[Family member] has a good breakfast and the food although not restaurant standards is homely. The staff provide lots of drinks throughout the day, I had lunch here today it was good." Another said, "The food here is lovely, my aunty never complains about it."

People told us they were asked what they would like to eat in the morning, however there was no menu provided to serve as a reminder. One person told us, "They come around and ask what you want to eat, but you can forget what you have ordered." Another said, "We never know what we are going to eat but I guess it's nice to have a surprise." However, we saw that if people didn't like what was on the menu they could have something else. One person told us, "If you don't like the food they bring you can have an omelette or jacket potato." People told us consideration was given to people's preferences regarding mealtimes. A person told us, "I only like wholemeal bread and I always have it." Another reported, "I have sore gums and the manager has arranged I have liquidised food." A visiting relative said, "They are very good here, my mum only enjoys small portions of food and they always give her that."

We observed the lunch time experience and saw there were no menus on the table and no napkins. People were given torn off squares from a paper roll. The only vegetable served with lunch was chopped swede. We saw very little communication between staff and people at mealtimes. On a positive note, both the regular agency and permanent care staff demonstrated that they knew people's likes and dislikes with food. They were aware when people did not eat their meal so offered them something else to encourage them. This was in contrast to a new agency staff member who was quick to remove people's plates and did not offer people who had not eaten much an alternative.

We spoke with the registered manager regarding the mealtime experience and mixed feedback. They advised us that they had run out of napkins on the day we visited and this would be rectified. They also told us they had now recruited a permanent chef and confirmed they had ordered menu holders for the tables to support people with their meal selection.

People's care records showed that they were supported with their healthcare needs, including receiving attention from GPs, dietician, speech therapy, district nurses as well as having access to routine healthcare checks from healthcare professionals such as the optician, dentist and chiropodist. However, people were not always positive about the support they received regarding healthcare. One person said, I am waiting for a replacement catheter bag and have to keep asking about it, I have been told it is in hand." Another said, "I have a skin problem, but it was not until the sores broke out that the cream finally arrived." We saw evidence that the new manager had been pro-active in developing close working relationships with healthcare professionals to try to secure good outcomes for people. We spoke to several visiting healthcare professionals who were positive about the service. One said, "It is a really pleasant home, staff are really helpful, they listen to my advice and are forthcoming in telling us about any concerns. [Named senior] is always here and is amazing. There are lots of different staff here sometimes but they seem to keep up with the work and is helpful." Another told us, "When people are complex and maybe not appropriate placements I support them as they are thrown in at the deep end; They recognise their limitations and will ask for help; I support with end of life and repositioning, ensuring they have the right equipment in place for people."

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found that confidentiality was not always upheld as people's care records were not always stored securely. We also found that records were stored in one room on the ground floor which made it difficult for staff working upstairs to access information about people's care needs. At this inspection we found that the new registered manager had addressed our concerns and people's care records were now kept locked away and were stored on each floor.

We observed that staff were kind and caring and this was reflected in feedback we received from people. One person told us, "The staff are really nice, you couldn't wish for any better." Another told us, "They [staff] are very kind to me." Another person said, "The staff come in and cut our nails, keep them nice." This person took pride in showing us their beautifully painted nails. She said, "A staff member painted them for me." During our first visit which was the day the clocks went back we saw that staff had taken the time to adjust all the clocks and people's wrist watches so that they were aware of the correct time.

Feedback about the kindness of the new registered manager was also positive. One person told us, "The manager is very good now, she knows I love cats and I am allowed to have the cat, in my room and look over there is the food bowl and water he likes."

However, despite the positive feedback about the kind and caring nature of staff, people also reported that many of the staff did not really know them and often did not have time to spend with them to engage in meaningful or sustained interactions. People's experience of being cared for and about was heavily influenced by the large number of temporary care staff employed. Comments included; "The only thing is here we have a lot of agency staff, most of them are very kind but don't really know you." And, "Because we see a lot of different staff they do not know you well." And, "I don't like seeing so many different staff, I love it when the lady is here who has been here a long time she will sit and chat to you."

Staff told us how they always held people's needs in the forefront of everything they did. They told us they would like to be able to spend more time with people to meet their emotional needs. However, due to staffing issues this was not always possible. One staff member said, "Our workload is heavy so we do not have time with people." We saw that regular staff laughed, joked and joined in with people who used the service when they could.

Throughout our inspection we did observe some positive interactions between staff and people. Staff displayed warmth when interacting with people and spoke to people politely and with kindness. Staff called people by their preferred names and asked permission before providing any care or support and respected people's privacy, knocking on doors before entering. We did not see any breaches of privacy or witness anyone being treated in an undignified manner. People told us that they were supported to have baths or showers when they chose which meant that their dignity was promoted. One person said, "You can always have a bath or shower, just ask." Another said, "I have a bath once a week but you can have more if you want to." Another told us, "I have a shower or bath when I want to, and staff do encourage you to have one at least once a week and they will even wash your hair for you."

People's independence was respected and promoted. Staff told us they encouraged people to do things for themselves. One person told us, "I am happy, I come and go as I please; I like to smoke and can go outside and sit in my wheelchair and smoke and the staff often bring me a cup of tea out here."

People were supported to maintain relationships that were important to them. A person told us, "My family can visit any time, and can always ask to have a meal here." Relatives confirmed they were welcome at the service. One relative said, "I can visit any time I want."

We saw that there had been discussions with people regarding their preferred priorities for care which included decisions about their end of life care. Do not attempt resuscitation forms (DNARS) were in place for people where appropriate and had been discussed with the person or their representative.

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care plans and saw pre-admission assessments were used to learn about people's individual care needs before they moved to the service. People or their relatives were included in the assessment process to develop their care plans but there was no evidence to show that people had been involved in reviewing their care. We saw that individual sections of the care plans, such as mobility, personal care and nutrition plans were in place. They were evaluated on a monthly basis however; members of staff conducted these evaluations and there was nothing to show that people were included in the process. This meant that care was being reviewed but not in an inclusive and person-centred way. A person told us, "I have not been asked about my views on living here; we have had so many managers here."

We spoke with the new registered manager about our concerns. They told us that they completed a walk around every morning and were out on the floor working with people and staff. This practice allowed them to complete ad hoc reviews with people on an informal basis, checking that people were happy but this was not formally recorded. People confirmed that the manager and staff were available to discuss their care needs with them. One person told us, "We have not had a review meeting, but you can speak to a senior or the manager at any time." After our second inspection visit the provider supplied us with an action plan which set out a timetable to review all people's care plans by 17th November 2017 to ensure that all care documentation accurately reflected people's current needs. However, it was not clear from the plan whether people and their representatives would be included in these reviews.

Person-centred care requires an understanding that each person is different, knowing people's likes and dislikes and providing care and support the way people want it. We found that people's care records contained sufficient information about people's needs and preferences which would support staff to get to know them and be able to deliver person centred care. However, because many of the staff supporting people were not permanent they had not read people's care plans and lacked knowledge about people. In addition, taking a person-centred approach requires time. We asked staff whether they thought they were providing person-centred care to people. One staff member said, "Not at the moment no, some days I could answer 'yes' to that question but we could do better." Another staff member said, "We do not have time to do the extras but we do try. I am spending most of my time telling agency staff what to do." People also felt that the care they received was not person-centred. One person told us, "How can they treat you as an individual person when they don't really know you, so many different staff look after you." Regular staff told us because they had worked at the service for some time they did know people well and the feedback we received from people confirmed this. People's perception of how well staff knew them differed depending on which staff were on shift. Comments from people included, "The regular staff know what you like and don't like but there are so many bank staff you have to tell them what to do." Another told us, "I think the staff probably treat us all the same and do what they have to but do not really know us well enough." Temporary staff's unfamiliarity with people meant that people's preferences were not always known and upheld. One person told us, "It is nice living here but I really only ever talk to the regular staff member who has been here a long time. She knows what you like and don't like."

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider was made aware of our concerns and after our second inspection visit they submitted an action plan which stated that 'dementia mapping' was to be completed by the end of November 2017. Dementia mapping is an established approach to achieving and embedding person-centred care for people living with dementia and is recognised by the National Institute for Health and Clinical Excellence as best practice. In addition, during our third inspection visit we saw that changes to practices around sharing information about people with agency staff had been made. This meant that temporary staff would have easy access to more detailed information about each person which would support the delivery of a more person-centred approach.

At our previous inspection we found that the home environment was not 'dementia friendly'. There was a lack of stimuli around the home such as clothing, rummage boxes, pictures and objects to engage people's interest and stimulate conversation and reminiscence between staff and people. During this inspection we found this was still the case.

We discussed our concerns with the new registered manager regarding a lack of improvement in this area. We have since received an action plan from the provider setting out a plan for a more dementia friendly environment to commence at the end of November 2017.

Our observations over the course of our inspection demonstrated a lack of activities, engagement and social interaction for people. Staff told us that they did not often have enough time to engage with people in a social way. One said, "If I have time I do sit with the ladies and watch the dancing on the TV and we have a chat about it." We did not see any activities during our inspection either in communal areas or on a one to one basis with people in their rooms. On our first visit during the early evening, on the first floor most people were either in bed or in their bedrooms. We saw that some people had their televisions whilst others were asleep in their chairs or in bed. The registered manager explained that some of those people were in their rooms by choice and had put themselves to bed. However there had been no exploration as to why people were choosing to go to bed at such an early time, for example, through boredom or lack of stimulation. We did see a senior staff member encouraging a person to play their key board, but they did not have sufficient time to remain with the person while they played and the person soon stopped.

Downstairs there were eight people in the living room watching television with little interaction from staff apart from when tea was being served. However, one person did say that a member of staff had spent time with them earlier in the day painting their nails. Comments from people regarding the level of activities included; "They sometimes have activities going on, if the lady is here." And, "One staff member will often sit and have a chat to us early afternoon." And, "One bank agency staff who works here a lot will sit and talk to you and have a laugh." A visiting relative told us, "My mum is in bed most of the time, and would love someone to come and have a chat but they are too busy to do this." On our second day of inspection there was an extra staff member on duty downstairs and we did observe a regular agency staff member communicating well with people. They appeared to know their likes and dislikes and spent some time just sitting with people and talking to them.

We discussed our concerns with the registered manager regarding the lack of activities for people. They advised us that since our last inspection the provider had recruited an activities staff member who worked Mondays to Fridays organising a range of activities both group and one to one with people. However, this member of staff was absent throughout our inspection visits so it was not possible to observe any positive impact this may have had on people. After our inspection we were provided with a copy of the activity diary for November which described how people had been supported to enjoy a range of one to one and group activities such as arts and crafts, games and quizzes and trips out.

The level and quality of activities described in the activities diary did not match up with people's feedback and perception of what was available. We therefore recommend that the provider review their current provision of activities to promote the engagement and wellbeing of people who use the service.

There was a complaints policy and procedure in place and people told us they knew how to make a complaint. At our last inspection, due to the large turnover of registered managers many people and relatives told us that they did not know who the manager was so were not clear on who to complain to. At this inspection we found that the new registered manager had addressed this issue by ensuring they were visible and accessible. All of the people we spoke to knew who the manager was and confirmed they would speak to them if necessary. One person said, "Yes I would know how to complain, in fact I have and the new manager sorted it out immediately." Another said, "I have complained and the manager here now will listen to you." A relative we spoke with said, "I have complained here once and the new manager sorted it out straight away, I won't go into details." We saw that the manager recorded complaints, responded appropriately and met with people and relatives in person to listen to people to try to address their concerns.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in February 2017 there was a new manager going through the registration process however they resigned from the company before their registration was completed. At this inspection another new manager had been recruited and was now in post. The new registered manager understood their registration requirements including notifying us of any concerns in a timely manner.

At the previous inspection there was confusion amongst people and relatives regarding who was in charge. People were not able to name or identify who the manager was. This meant people did not know who to raise concerns with and did not feel listened to or included in how the service was run. At this inspection we found that the new registered manager had worked hard to address this issue by ensuring they were visible and approachable, working out on the floor alongside staff. This hands-on approach meant that people now knew who the manager was and people spoke highly of them. One person told us, "[registered manager] is always around to talk, she does really long days, puts in an awful lot of effort, I think she is doing a great job." Another said, "The new manager here is very friendly, and if she sees you will always speak to you." And, "I do see the new manager walking about." Relatives also commented on the improvements in leadership style. One told us, "The new manager is very approachable here and friendly." Another said, "You can speak to the manager at any time and she will listen to you."

Staff also spoke well of the new registered manager and were appreciative of the effort and commitment they had shown to supporting staff and working towards making the necessary improvements. One staff member said, "The manager is running around, helping us, making up any shortfalls, and getting people reviewed who we can't meet their needs." Another said, "The new manager supports me all she can but it is difficult for her having to use so many agency staff." Feedback from healthcare professionals about management was also positive. One told us, "They've improved tremendously; [registered manager] is pulling it together."

Despite the positive feedback we received about the new registered manager, we found that the significantly high turnover of managers over an extended period of time had impacted on the quality of the service people received. The long term managerial instability meant there was a lack of consistent oversight and leadership at both manager and provider level. The registered manager had been post for a relatively short period of time and had inherited a number of longstanding issues that we had found at our previous inspection in February of this year. We saw that they had made some headway with regard to making the required improvements. However, due to insufficient support from the provider, with particular regard to staff recruitment, the registered manager had neither the time nor resources required to implement and sustain the robust systems and processes required to effectively monitor and improve the safety, quality and effectiveness of the service. Consequently, many of the issues we found throughout our inspection had not been identified or addressed. For example, although monthly environmental audits were completed these had not picked up on the hazards in the kitchen or the wardrobes not being bolted to the walls.

This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Due to the nature and severity of our concerns outlined throughout this report we wrote an urgent action letter to the provider detailing the areas that required immediate improvement to ensure the safety and wellbeing of people who used the service. We found that the provider's response was both positive and pro-active. They supplied us with a robust and detailed action plan which set out their plans to address the issues we found within a set time frame. Their plan included the commitment to hire a specialist consultancy to work alongside the staff team providing ongoing support and guidance. During our third inspection visit we saw that this support mechanism was already in place and both staff and the registered manager reported feeling more supported. We saw evidence of new systems and processes being implemented, however it was too soon to comment on their effectiveness as they had not yet been fully embedded in practice.

Whilst staff and the registered manager felt stressed and under pressure due to the difficulties within the workplace, which centred around the lack of a stable and consistent workforce. Nevertheless the culture within the service, expressed by the regular staff team, was very caring and committed to driving improvements and providing good quality care.

Since the new registered manager had been in post there had been the introduction of a daily morning meeting which was an opportunity to share information between the staff team and promote accountability. Whilst these meetings were not always consistent, we saw that when they occurred they had been used positively to highlight actions that needed to be addressed and check that previously discussed actions had been completed. For example, where an infection control audit had picked up that some carpets needed deep cleaning. This had been discussed and actioned through the daily meeting.

At our previous inspection we found that the provider had not taken the necessary steps to obtain feedback from people regarding the quality of the service, for example through satisfaction surveys or residents meetings. At this inspection we saw that whilst residents and family meetings had not been re-introduced, a satisfaction survey had been sent out to people in 2017 to solicit their views. We did note on the action plan subsequently submitted by the provider that there were plans to re-introduce family and residents meetings with a date already set for a relatives meeting of 1st December 2017.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's routines and preferences were not always known or upheld and the care provided was task-focussed rather than person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Ineffective quality assurance mechanisms and a lack of support and oversight from the provider meant that the service had failed to identify and address many of the concerns we found.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff deployed with the right skill mix to safely meet people's needs.