Alliance Care (Dales Homes) Limited

Houndswood House Care Home

Inspection report

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Date of inspection visit:
04 October 2016
12 October 2016

Date of publication:
27 January 2017

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

The inspection took place on 04 and 12 October 2016 and was unannounced.

Houndswood house care home provides residential and nursing care for up to 50 older people, some of whom live with dementia. There were 45 people living at the home at the time of this inspection.

There was a registered manager at Houndswood House. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were informed by the provider that after this inspection the registered manager and deputy manager both resigned.

When we last inspected the service on 10, 11, 16 and 18 August 2016 we found the service was in breach of regulations 09, 12, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that there were sufficient numbers of staff to keep people safe at all times, and people did not always receive personal care in a timely way. The provider had failed to provide people with opportunities for engagement and activities and there were concerns relating to the management of medicines. The provider's governance and quality monitoring systems also had not been effective in identifying these areas.

Following our inspection in August, we received an action plan to tell us how they would make the required improvements to meet the legal requirements. At this inspection we found that the provider had not made sufficient and sustainable improvements and further improvements were required. They were found to be in breach of regulations 9, 10,17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the current inspection we found that people were left in communal areas with no staff present for three separate periods of up to 10 minutes. People were not always assisted or supported in a timely way and they did not always have access to their call bells to enable them to summon assistance when required. Staff had not received the training necessary to give them the skills and knowledge to support people's individual health conditions, in particular people who lived with dementia. "People`s nutritional needs were not consistently met by staff." People were not always supported to engage in daily activities. Engagement was inconsistent and did not provide people with meaningful engagement or stimulation.

The provider had arrangements in place to monitor the quality of the service; however this was not always effective in identifying and addressing areas that fell below the required standards.

People and their relatives were complimentary about the care staff and told us they were kind, compassionate and caring. However, we found that the staff were not always able to spend quality time with people. The care provided was task orientated and did not support a dignified approach for people. The

dementia unit was not decorated to reflect best practice for people with dementia offering little to provide stimulation or interest.
The environment in particular on Magnolia unit was 'scruffy' in appearance and was in need of refurbishment in order to provide a dignified home for people to enjoy. The provider acknowledged this and an extensive refurbishment plan was place, the date for commencement of the refurbishment was to be confirmed.

Some of the people told us they felt safe living at Houndswood house care home, however others felt there were not sufficient staff to keep them consistently safe. Staff demonstrated they knew how to keep people safe and risks to people's safety and well-being were assessed and recorded. However these were not always managed effectively. The home was busy at times and staff were struggling to keep people safe. The provider had a robust recruitment process in place which helped to ensure that staff employed were suited to work in a care home environment. However two out of six staff spoken with had difficulties understanding and answering our questions because of their limited English language skills. People's medicines were not consistently managed and administered safely by staff. The most recent audit identified that a number of errors were still occurring.

Staff received regular support from their line managers and had one to one supervision meetings where they discussed a range of topics relevant to their roles. Staff did not always feel valued by the management team. Some of the people received the support they needed to eat and drink sufficiently to maintain their health, however people were not always supported in a timely way. People were supported to keep well in most cases their health needs were well taken care of with appropriate referrals made to a range of health professionals when required.

Regular staff were knowledgeable about people care and support needs and preferences and where possible people were involved in the planning and review of their care. However agency staff and 'replacement staff' did not always have the same understanding of people's needs. People were asked for their consent and this was documented in people's care records. Visitors were welcomed to the home at all times. The provider had systems in place to obtain feedback from people who used the service, their relatives, and staff about the services provided. There were quality assurance systems and audits in place to help monitor the service however this was not always effective in identifying some of the shortfalls we found during the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always sufficient numbers of staff on duty to meet people's needs.

Risks to people's health and well-being were assessed but not always managed effectively to keep people safe.

People's medicines were not consistently managed safely. Medicines were stored securely and there was a robust system for ordering medicines.

The provider operated a robust recruitment process. However we found that some staff had a limited command of the English language.

Staff were able to describe what constituted abuse and knew how to report concerns.

People told us they felt safe at Houndswood house care home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received care and support from staff who were not always appropriately trained and supported in their roles.

Some people were involved in decisions about their care. Staff were aware of the need to obtain consent but not all of the staff knew about the principles of the Mental Capacity Act.

There were inconsistencies around the availability of snacks for people. Some people were supported to enjoy a healthy diet. Food was not always provided in a timely way.

People were supported to access a range of health care

professionals to help ensure that their general health was maintained.

Is the service caring?

Requires Improvement

The staff were kind and caring.

Staff demonstrated a good understanding of people's needs and wishes and were kind, caring and respectful when supporting people.

People were supported to develop relationships with staff when possible.

Staff treated people with dignity and respect, as much as possible based on time constraints.

People's personal records was stored securely.

The environment in need of refurbishment to maintain and promote people's dignity and well being.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some of the people were sometimes supported to engage in activities but these were inconsistent and not person specific and did not provide people with meaningful engagement or stimulation.

Staff did not always receive training about people's specific health conditions to enable them to meet their individual needs.

People's concerns were not always listened to, with timely actions taken.

People's care was kept under regular review to help ensure their needs were met. However peoples needs were not always responded to in a timely way.

People were supported to raise complaints or issues about the service and these were processed through the complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems and processes in place to monitor the overall quality of the service provided in the home however; these were not always effective in identifying and addressing areas that required improvement.

The home was not always maintained to a satisfactory standard.

Audits were not always analysed or used to drive improvements.

People's relatives were not confident that the standards of care at the home had improved since our last inspection.

Staff did not feel consistently supported in their roles.

Audits were not always analysed or used to drive improvements.

Houndswood House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 04 and 12 October 2016 and was unannounced. The inspection was undertaken by two inspectors and the 4 October 2016 and on the 12 October 2016 one inspector.

Before our inspection we reviewed 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.

During the inspection we observed staff providing support to people who used the service, we spoke with two people who used the service, six members of staff, the registered manager, deputy manager and representatives of the providers senior management team. We obtained feedback from five relatives as part the inspection.

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. We received feedback from the local commissioning team at Herts CC.

We reviewed care records relating to four people who used the service, engagement and activity charts and other documents relevant to people's health and well-being. These included staff training records, medication records and quality monitoring audits and the most recent action plan updates.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection of Houndswood house in August 2016 we found there were not always sufficient staff available to keep people safe. We found that people's medicines were not always managed safely and that we could not be assured that people had received their medicines in accordance with the prescriber's instructions. Risks to people's health and well-being were assessed but not always managed effectively to keep people safe. The provider operated a robust recruitment process. However we found that some of the staff had a limited command of the English language.

At this inspection, we found that whilst some improvements had been made further improvements were required. The majority of people were unable to tell us if they felt safe living at Houndswood House due to their complex health conditions, or if they felt there were sufficient staff on duty at all times. However, feedback obtained from five relatives and our observations told us that there was not enough staff to meet people`s needs safely in a timely way. We observed that people were not always kept safe.

On three occasions people who lived with dementia were left without any staff being present for between 5-10 in the lounge and dining room. During this time we observed a person who was very unsteady on their feet get up and walk across the room, an inspector stood close to them to support them in the event of them falling. We observed another person displaying threatening behaviour towards another person waving an item close to their face. We had to find staff who were busy assisting other people to manage the situation between the two people and keep them safe. We also spoke to a manager about this who took action to address this risk.

Due to the lack of available staff to keep people safe we found that this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed that for two people we spoke with in their bedrooms their call bells were out of reach. We established that both people had capacity and were able to use the call bell. We spoke to a staff member about this because without access to the call bell the people could not summon assistance if required. The staff member told us they were 'agency staff' and had just finished assisting the person and said it was an 'oversight'. Staff told us they did check people in their bedrooms regularly however as the people had recently been checked and this was recorded in their notes it may have been at least an hour before anyone checked on them again.

We found that potential risks to people's health and safety had been assessed and actions put in place to mitigate risk where possible. We saw that risk assessments were in place for moving and handling, including the use of slings and equipment, the risk of developing pressure ulcers, and falls. These assessments were detailed and identified potential risks to people's safety together with guidance to mitigate risk. However we found risk assessments were not always updated to reflect current risk. In the case of one person they had lost a significant amount of weights and this was not reflected on the risk assessment. In the case of another person who had sustained two falls in 24 hours although the care plan notes had been updated with a record of the falls, the risk assessment did not reflect an increase in the risk to the person. This meant that

staff had not had the most up to date information to help them manage the risks effectively.

We saw that accident and incidents were appropriately recorded. However, they were not always analysed and actions were not put in place to keep people safe. For example, we noted that two

people had severe bruising to their face. Staff told us one person had fallen the week prior the inspection and the other person had fallen twice in 24 hours. One fall was witnessed and the other was unwitnessed. One staff member told us, "You cannot watch people 24/7". However there was no analysis around the time of the falls or the circumstances which may have helped mitigate the risk of the person having the second fall.

Staff had received training about how to recognise and report abuse and how to protect people from harm. Staff demonstrated that they knew how to identify and report potential abuse. Training records confirmed that most staff had completed online safeguarding and three staff were due to have refresher training in the next two months. Information about how to report concerns was displayed in the home and was accessible to staff and visitors. Staff were able to describe how they would report any concerns. For example, staff told us that people living at the service were observed for changes in their behaviours or any unexplained bruising which could indicate possible abuse.

The recruitment process had improved since our last inspection and we noted records were checked to ensure they were all correctly completed and that all pre-employment checks were done before potential staff commenced their employment. However we found that two staff members were unable to answer our questions due to their limited understanding of the English language. We spoke to a manager about this as we were concerned if people who used the service could not make their needs known to staff, this could place people at risk of harm.

Medicines were not always managed safely. We observed the medicines trolley in use on Magnolia unit was broken and could not be locked. However we saw that it was positioned in the middle of a central corridor. The Nurse administering the medicines told us they were taking it in and out of the nurse's station in between the administration. We did not observe this happening so could not be assured that it was happening but noted the medicines round which commenced at 8.15am was still in progress at 10.15am on the first day of our inspection. We also saw that a recent audit of medicines showed a number of medicines errors were still occurring and actions from the audit were still in the process of being put in place to try and reduce the risk of them reoccurring. This included additional competency checks for staff who administered medicines.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found that people were not always supported to eat and drink in a timely way and in particular around the availability of snacks and drinks. At this inspection we found similar issues in particular on the unit where people lived with dementia.

We observed on the Magnolia unit there were no snacks on display and only a jug which had a small amount of juice which was tepid. We spoke to staff about this to establish why this was happening as following our previous inspection the registered manager told us that 'finger food and drinks' would be visible to prompt people who live with Dementia and who may not otherwise be able to ask for snacks or drinks. A member of staff told us they could not leave snacks out because one or two people 'touched' them and another person removed them'. The member of staff did get two jugs of fresh juice. They told us that snacks were available but were 'locked'' in the Nurses station and that people would be offered snacks at certain times in the day. We elevated our concerns to the manager who told us they were considering various options to try and manage this issue effectively.

We also noted that people who were mainly cared for in their bedrooms were not routinely offered snacks or healthy options. We spoke to a visiting relative who told us "I am not aware of (relative) being offered any snacks I do think they would enjoy something if it was available". We checked the notes in the person's bedroom for the previous five days and saw that there was no record of any snacks being offered. Likewise we checked the records for two other people who were in their bedrooms during our inspection and saw that there was no record of them being offered a choice of snacks in the previous five days. This confirmed that people who were not in communal areas were not offered finger foods on a regular basis.

People were unable to tell us if they were happy with the standard of food they received due to their complex health conditions and people who lived with dementia did not understand what we were asking. We observed that on both units people were offered a choice of food. People were supported appropriately to eat and drink during the lunch time service. However we found that three people who were being cared for in their bedrooms and who required support with their lunch were not assisted until 1.30 an hour after lunch service commenced. We asked staff why these people were not supported sooner and were told that they had to assist people in the dining room first. People were not able to tell us if they had been consulted about this arrangement. We observed their meals were kept warm on the heated trolley.

People were weighed monthly. Staff confirmed that unless there was a concern about unexplained weight gain or loss in which case people's weight was monitored weekly. We saw that a person had lost 4.5 kilos in the last three months but had not been put on weekly weights and no referral had been done to a dietician or to the persons GP. We spoke to managers about this to establish why this had not been picked up and actions put in place to monitor the person. Managers took appropriate action and the person was put on weekly weights and a referral was made to a health professional for advice and support with ongoing management. People were unable to tell us if staff had the appropriate skills and were knowledgeable about how to support and care for them due to their complex health conditions. We received feedback from relatives who told us, "The skills and abilities of staff varies, some are better than others." Another relative

said, "They do their best, but they are always so busy, so often cannot pay attention to detail." Another relative said "The regular staff knows the ropes, agency staff or support staff (staff who routinely work in housekeeping, laundry or activities) often don't have the same level of experience as the regular staff".
People were cared for by staff who had completed an induction which covered topics such as moving and handling, infection control and safeguarding. Staff confirmed they received on-going training. Managers told us more 'face to face' training was being introduced as historically most training was computer based. The latest action plan recorded that all staff were to be provided with 'Dementia' training. We asked the regional manager to confirm that this training had been completed by all staff at Houndswood House. They told us that staff had not yet had the dementia training but would be over the coming months. We were told and records confirmed that staff had undertaken some 'impact' training which is a type of 'role play' where staff were given an opportunity to 'experience' how life was for people who lived with dementia.
Staff gave us mixed views when asked if they felt supported by the management team. Staff told us they thought that things had improved since the last inspection. One staff member told us, "I do not feel that we always get the support we need." Another staff member told us, "It varies, we do have team meetings and individual meetings with our managers but it does not always feel like support." One relative told us "We don't see the managers much on Magnolia unit they spend their time on Primrose."

We observed staff obtaining consent from people and explaining how they were going to support them. Staff spoken with told us they always obtained people's consent before supporting them. We saw that care plans had been signed to confirm their consent. In some cases people's relatives had been involved in the process where they had the legal right to do so, and the person wanted them to be involved to assist with decision making.

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 two staff members we spoke with had limited understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. We spoke to the manager about this as we found there was difficulty with staff understanding our questions due to English not being their first language. The registered manager told us about the process they would follow to ensure any decisions put in place were in the best interest of the person. This included liaising with the local authority and other professionals or family members involved in the person's life to decide the best action necessary to ensure that the person's needs were met effectively and that met the legal requirements.

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 found that applications had been made under DoLS, some had already been authorised while others were pending authorisation.

People were supported to maintain their health and wellbeing. Staff told us and records confirmed that people were able to access a range of relevant healthcare professionals should they need to. This included GP appointments. GP's visited the home regularly and on request. This showed that people received support from healthcare professionals to help maintain their health.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection in August 2016 we observed staff being kind and caring to the people they supported. However we saw that they were 'rushed' which meant that on occasions they could not pay attention to detail because of constraints on time.
During this inspection people and their relatives told us they were happy with the staff that provided their care. A relative told us, "The staff are marvelous, they really are there is just not enough of them".

We observed that a person had removed their trousers and continence product and was stood with the bottom part of their body totally exposed. There was no staff present in the lounge at the time. An inspector had to go and find staff to assist the person and try to protect their dignity. We spoke to the manager about this incident which has compromised the person's dignity. We were told staff had been assigned to support people in the communal lounge however they were busy supporting other people at the time.

We observed care to be basic and task orientated and the routines were based on the availability of staff, rather than responding to people's needs. Staff did not always respect people`s choices and wishes. We saw that staff assisted people when they had time. For example one person told us, "I am waiting for someone to help me get washed and sit out in my chair." We found a member of staff (the person's call bell was out of reach so they could not summon help). We asked the staff if someone could assist the person and the staff member told us, "I will come to them next when I finish what I am doing." However the person told us they had already asked to be assisted earlier when they got their breakfast but staff had not returned to assist them. Staff told us they had been back to the person but found them to be sleeping, however there was no record of this interaction. This demonstrated that people's personal care needs were not always met in accordance with their assessed needs, wishes or preferences.

People were not consistently cared for in a way that demonstrated staff respected people's choices or followed their personalised care plans. We reviewed bathing records and spoke to staff about the frequency of personal care. We found that people were not always supported with personal care in a timely way or on a regular basis. One person was observed to have 'soiled trousers' on and this was the case throughout the day. We spoke to the manager about this in the afternoon and they told us they would address this with staff. One relative told us, "My [person] only received a bath three times in the previous month."

We saw that there were many positive interactions throughout the day and staff really demonstrated they knew people's needs well. One person told us, "The staff are lovey, most of them, yes they are caring." Feedback obtained from relatives confirmed that staff were kind and they felt overall their relative was 'well cared for' by staff given the pressure on their time.

However three people's relatives provided negative feedback which included comments such as "Actually since the last inspection, I must admit personal care seems to be absent, I feel my [relative] stays soiled often for long periods and it's uncomfortable for them and obviously for me and other people around them. Also their clothes always seems dirty I feel if when they spills drinks or food or they should be changed into clean clothing". Another relative commented "[Relative] required assistance during our visit we informed

staff and brought relative back to their bedroom to await assistance. However after 20 - 30 minutes, no-one had come. We went to request staff help us and found they had 'forgotten". A third relative told us "It remains the case, that some of the staff are very caring. Some of them know the residents well and are very kind and patient and adopt an appropriate manner for each different person. However, some are more offhand, and some spend time talking to each other in the sitting room, when they could be engaging residents in conversation or activities, or visiting residents who have chosen to stay in their rooms". A further comment was "Sometimes their manner (staff) with the residents is not appropriate, for example a joke that residents might take seriously, or not understand".

Due to the lack of dignity and respect and poor care delivery and care plans we found that this was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

When we inspected the home previously in January 2016 we noted that the environment was 'scruffy' with chipped paint, soiled upholstery, bedlinen that was 'tired' and well worn. We were told that there were plans for a refurbishment. However the manager told us although this was still planned and delayed for nine months. At this inspection we noted that the flooring had been replaced on Magnolia unit. However the refurbishment had not happened and was not pleasant, stimulating or 'engaging' for the people who live there. The regional manager told us that a full refurbishment of the home was planned for the near future.

The support manager told us that visitors were able to visit at any time, and we saw from the visitor's book that people visited regularly and at different times of the day. We saw that information held about people's health, support needs and medical histories was kept secure and information was only shared with people who had authority to access it.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection of Houndswood house in August 2016 we found that people did not have sufficient opportunities to take part in meaningful activities and engagement relevant to their needs, preferences and abilities.

People were not able to tell us if they were happy with the support they received. However several family members raised concerns about how responsive the service was to meeting people's needs.

We observed that some activities were provided on Primrose unit. People were also getting their hair done. However activities for people who remained in their room were inconsistent and staff were not aware of what activity people had participated in.
Since the last inspection a new 'activities staff member' had been employed and they were still being 'inducted' at the time of our inspection. The support manager told us activities were being reviewed to make them more personalised and meaningful for people. Relatives told us that there were 'no activities' provided at the weekend, however the regional manager refuted this and told us that activities were provided at the weekend. On the day of our inspection we observed that four people were taken to the garden centre for two hours in the morning, with two members of activities staff. During this time no activities were provided to the people who remained at the home.

We reviewed the activities programme which activities staff told us was what was planned, however they told us that this could be changed depending on what people wanted to do. We reviewed activities records and noted that people who were cared for in their bedroom had one to one time recorded most days. When we asked staff who provided the activity, what the activity was or how long the activity was for they could not tell us and said they did not record that level of detail. However after further discussion about how they ensured people were being 'engaged' it became apparent that one to one was often personal care or being assisted with a drink or food which was a 'basic' care task function and was not something that was an 'interest or hobby' which people could enjoy. This demonstrated that engagement and stimulation did not reflect people's preferences and needs.

For example, we observed in the lounges on each unit the television was on but there was also music playing. People were not engaged with what was on and the volume was so loud that any potential for communication or conversation was not possible. One relative told us, "There are not enough activities that people can participate in. Another relative told us they were not aware of their relative being offered any engagement and had not seen anything recorded in their daily progress notes which they reviewed when they visited.

Due to the lack of meaningful engagement for people living with dementia and poor care delivery and care plans we found that this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
People and their relatives were asked to complete surveys to obtain feedback on the service. Following the return and analysis of these an action plan was developed. A summary of 'you said' we done' was displayed

in prominent places in the building so people know what had changed as a result of their feedback.

The service had a 'resident of the day scheme'. All staff were aware of who was the resident of the day which included the nurses, care and activities staff, the chef, a housekeeper and admin staff who all supported the person to have an enjoyable day. For example staff told us they got special treatment and were pampered which included getting their nails done or a hand massage.
We saw that some people's relatives were invited to attend monthly reviews of people's care plans. This helped to ensure that people's care plans were reviewed at least once so that the service could respond to peoples changing needs when required. We saw that communication with people's relatives was recorded. For example, we noted that one person's relative had suggested a medicines review and another person had been contacted to be informed that their relative had a fall.

People were unable to tell us if they knew how to raise concerns or complaints. Relatives told us they were able to speak with managers to share concerns. However two relatives told us they were not confident that complaints were addressed or acted upon. We saw that complaints had been recorded, investigated and responded to. Another relative said they preferred to speak to staff as they found the management team were "not always so receptive to concerns raised."

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Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in August 2016 we found that the service was not consistently well managed. Management systems and processes were not robust and required improvement to identify and address areas of shortfall and drive improvement. Following our inspection in August 2016 we received action plans demonstrating how the provider intended to address the shortfalls. However, during this inspection we found the provider had not made sufficient and sustainable improvements.

During this inspection we found that many of the issues we had previously identified had not been addressed. For example staffing levels was still an issue of concern, timeliness of support, the availability of food (snacks) and engagement required further improvements. Audits had not identified many of the issues we found during our inspection. We found that audits and monitoring of the service were not effective. For example a recent print out of call bell response times had been printed. However there was no analysis to establish why calls bell response times sometimes took 10-15 minutes. This meant that actions to improve response times were not introduced to achieve the required improvements.

Maintenance of the home was also a concern. The boiler was condemned on the 16 August 2016. However at the time of our inspection the boiler had not been replaced or repaired. This impacted on people who lived in Magnolia. For example the hot water was limited and reliant on an emersion which meant that if people wished to have a bath had to go to Primrose unit or accept a shower. People were provided with portable heaters which presented as a potential risk for people who lived with dementia. There had been numerous concerns raised in relation to the impact of the boiler being out of action. This included a risk of legionella. The manager told us they were 'flushing' the taps twice daily to reduce the risk. There was a concern about the drop in temperature and the registered manager had said in their emailed communication 'it was cold at night'. People had then been provided with heaters for their bedrooms. However no individual risk assessments had been completed in respect of these. We requested a copy of peoples risk assessments for the use of electrical heaters. These were provided two days after inspection and were 'generic' RA for the heaters (not for individual people or rooms).Despite repeated requests for the boiler to be fixed it took two months for the boiler to be replaced.

People were not always able to tell us if they were happy with the management of the service. Feedback received from relatives was mixed with some people saying that things had not improved since out last inspection. We observed that care was basic and often reliant upon the availability of staff. Relatives told us that they were not confident that their feedback and opinions were always taken on board. We found that while some actions had been put in place since our previous inspection to address some of the shortfalls these had not been embedded to make much difference to how the service operated due to the short period since our previous inspection. For example, daily 'flash' meetings for staff to report any concerns they had on their shift were in place however we could not see any direct improvements or impact on people's experiences as a result of these.

People who used the service did not know who the manager was and people told us the names of various people although most people we spoke with thought the deputy manager was 'in charge'. People's relatives

told us there was a high turnover of staff which was unsettling for people because they were unable to build relationships and felt they did not get to know them well. On relative told us, "The manager and deputy spend their time on Primrose, we do not see managers on Magnolia unit" Another relative told us that since the last inspection the manager had made themselves available to speak with relatives in the evening (as this was the only time some relatives could visit). Which they said they were pleased about.

The support manager told us that relatives meetings were arranged, however these were poorly attended an only the same few people attended. Relatives told us the notice for meeting was too short for them to attend and another person said they could not remember being invited to any relatives meetings. However we did see minutes from the last two meetings. The support manager agreed to review how and when this information is communicated to relatives and family members.

Staff told us that there did have regular staff meetings where there was an exchange of information and they were able to discuss any issues or concerns. The main issue staff felt was that staffing levels fluctuated and they often 'had to manage' despite people's needs being extremely 'challenging'. One nurse told us, "People are very challenging on Magnolia unit and it is really hard to plan, we often have incidents such as a fall or an emergency and then it puts everybody behind." There had also been a regular turnover of staff, and this meant that staff were sometimes working with staff who were less experienced. Staff told us they worked well as a team and tried to support each other. There were also clinical nurse meetings to discuss any clinical concerns.

Due to the lack of governance and effective monitoring we found that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Providers are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Due to the lack of meaningful engagement for people living with dementia and poor care delivery and a lack of personalised care plans

The enforcement action we took:

We are proposing a condition to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Due to the lack of dignity and respect and poor care delivery and care plans we found that this was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

We are proposing a condition to restrick admisions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Due to the lack of governance and effective monitoring we found that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

We are proposing a condition to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Due to the lack of available staff to keep people safe we found that this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

We are proposing a condition to restrict admisions