County Healthcare Limited

Clova House Care Home

Inspection report

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25 July 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This inspection took place on 19, 21 and 25 July 2017. The first day of our inspection was unannounced, the second day the provider knew we were returning and the third day was unannounced. At the last inspection, which took place on 17 June 2015, we rated the service 'Good'.

Clova House Care Home provides residential care for up 32 older people. At the time of our inspection, nine people lived on a unit on the first floor, which specialised in supporting people who may be living with dementia. Another 21 people lived on a residential unit which spread across the ground and first floor. The provider was supporting people in a dementia unit, but had not agreed with the Care Quality Commission to provide dementia care. This was discussed with the regional manager and will be addressed outside the inspection process.

During the inspection, we identified some areas of the service needed additional maintenance to ensure people's safety. For example, not all fire doors automatically closed and a fire escape was not properly maintained. A fire risk assessment had been completed, but appropriate action had not been taken to address the recommendations contained within it. Staff had not received fire training to meet the provider's fire procedures and we observed a poor response when the fire alarm sounded. We shared our observations with the local fire safety officer who visited the service in light of our concerns.

We found that medicine management systems were not always safe. The environment was not clean and infection prevention and control practices were not effective. We found mattresses and equipment contaminated with what appeared to be bodily fluids or showing evidence of ingrained dirt. Chairs and cushions were dirty. We found the provider was not compliant with Criterion 2 of The Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance.

There were gaps in staff supervision and appraisal. We found unsafe recruitment and induction procedures in relation to agency staff who were in widespread use. This meant the provider had not taken reasonable steps to ensure staff were suitable to work in the service.

We found staff lacked understanding about how positive support could be effectively used to guide people's care and promote their emotional wellbeing and safety. People's care plans were not always clear and were not consistently followed in practice. We identified concerns regarding the support provided for people to engage in meaningful activities.

There was a registered manager in post. 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 manager was present on all days of the inspection.

Since our last inspection, the service had not had continuity of managers as the registered manager had been away on extended leave and an interim manager had left the service before they returned.

At the time of this inspection, the provider and manager were working with the local authority to address concerns they had about some aspects of the care provided. We found the manager had begun to implement improvements the local authority had suggested. However, we identified on-going concerns around people's safety and wellbeing and concluded the provider had failed to ensure the manager had the support they needed in their role.

We found breaches of regulations relating to safe care and treatment, person centred care and staffing. We were concerned that the provider's management team and staff at the service had not identified and addressed these concerns. Audits to monitor the service were in place, but had been ineffective in monitoring and maintaining standards of hygiene and promoting good infection prevention and control practices.

Concerns raised with the provider regarding poor record keeping and care plans by the local authority had been acted upon. However, some records we looked at were not consistently maintained.

We identified breaches of regulations relating to safe care and treatment, staffing, person-centred care and the governance of the service. You can see what action we told the provider to take at the back of the full version of the report.

There were safe recruitment practices in relation to permanent staff. Staff understood their responsibility to identify and respond to safeguarding concerns.

We received mixed comments on the quality of the food from people who used the service. People did not always receive effective support at mealtimes to ensure they ate and drank enough. Applications for Deprivation of Liberty had been made and the principles relating to the Mental Capacity Act 2005 were understood by the staff we spoke with. The décor in the dementia unit was not suitably adapted to reflect best practice in dementia care. People had access to community healthcare services to meet their needs, and community staff told us that communication with the senior care staff was good. We observed staff being kind and people told us they were caring, but people's dignity was not always supported.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems for managing medicines were not safe.

The premises were not safe, specifically with regards to if there was a fire.

Risks were not always effectively managed.

People who required support were not always assisted in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

There were gaps in staff supervisions and appraisals.

Recruitment and induction procedures in relation to agency staff were unsafe.

People did not always receive effective support at mealtimes to ensure they ate and drank enough.

Consent to care was sought. Staff understood the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff did not consistently maintain people's privacy and dignity.

People told us the permanent staff were kind and caring, but there were concerns about the quality of care provided by agency staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who used the service raised concerns about the support available to access meaningful activities.

Care plans were not always clear and there were gaps in records regarding the delivery of people's care.

There were systems in place to gather and respond to feedback about the service, but these had not been acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's quality monitoring systems were not robust or effective in monitoring and improving the quality and safety of the service.

We received mixed feedback about the manager. Changes in management had impacted on the quality of the care and people's experience of using the service.

Clova 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 checked 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 19, 21 and 25 July 2017. The first day of the inspection was unannounced. It was carried out by two adult social care inspectors, a specialist advisor and an expert by experience. A Specialist Advisor is someone who can provide expert advice to ensure that our judgements are informed by up to date clinical and professional knowledge. The Specialist Advisor who supported this inspection was a specialist in nursing care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two adult social care inspectors returned to the service on 21 July 2017, when we were also assisted by two nurses from the Community Infection Prevention and Control Team. They provided specialist advice and guidance regarding the prevention and control of infection in a care setting. Two adult social care inspectors concluded the inspection on 25 July 2017.

The inspection was prompted in part by a notification of an incident following which a person who used the service sustained a serious injury. This incident is subject to further investigation and, as a result, this inspection did not examine the circumstances of the incident.

However, the information shared with Care Quality Commission about the incident indicated potential concerns about the management of risk of falls from beds. This inspection examined those risks.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority contract and commissioning team to gain their feedback and reviewed the information we held about the service, which included notifications the provider had sent us. Statutory notifications tell us about specific events which occur at the service and about which the provider is legally required to inform us of. We used this information to help us plan the inspection.

During the inspection, we spoke in private with eight people who used the service and had general conversations with a number of other people. We also spoke with six relatives of people who used the service.

We reviewed a range of records. This included eight people's care records. We also looked at the records for four permanent staff and four agency staff files relating to their recruitment, supervision, appraisal and training. We viewed records relating to the management of the service and a wide variety of policies and procedures.

We spoke with the manager, two regional managers, three senior care assistants, two maintenance staff, the chef, two 'resident experience' managers, the activities co-ordinator and the provider's health and safety advisors. We met and spoke with two healthcare professionals.

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. We looked at all the facilities provided including communal lounges and dining areas, bathrooms and people's bedrooms with their consent where possible.

Inadequate

Is the service safe?

Our findings

Risks to people were not being managed appropriately. For example, one person lacked insight into their impaired mobility. This combined with their heightened anxiety placed themselves and others at risk of harm. The person had a sensor mat to alert staff if they mobilised independently. On the first day of our inspection, we found the sensor mat was not working. We pointed this out to staff and, appropriate action was taken to recharge the battery. However, on the second day of our inspection, we found the sensor mat was underneath the person's bed and we were again concerned that staff would not be alerted if the person tried to get up independently. On the third day of the inspection, the sensor mat was in place, working appropriately and a member of staff immediately responded when alerted.

One person had equipment, which had not been transferred with the person when they were moved into a new room on the day before our inspection. A community nurse confirmed that this person needed the equipment to promote their safety and well-being. We reported this to the manager who took action to ensure this person had the equipment they needed. Whilst staff and the manager responded to our concerns, these examples showed us that risks were not always proactively managed.

A fire risk assessment had been completed in 2014. The last review on 11 August 2016 stated all staff needed to complete fire training, to include the use of fire equipment and evacuation procedures. A health and safety audit carried out on 12 July 2017 highlighted fire training for staff needed to include fire drills with evacuation procedures, to ensure staff were familiar with the procedures in place. During the first day of our visit the fire alarm sounded. We observed that staff did not follow the fire procedures and were unsure what to do. Agency staff we spoke with confirmed they had not received fire safety awareness as part of their induction into the service.

When the alarm sounded, we identified that not all of the fire door retainers were operational and fire doors had remained open. A fire door leading to the fire exit on the first floor had swung open putting people in this part of the service at potential risk in the event of a fire. We spoke with the manager and regional manager who arranged for work to be completed to address our concerns. During the second day of our inspection, fire warden training had been delivered and a nominated member of staff had been identified to act as a fire warden on each shift. The external door leading to the fire escape had been fixed. Although this demonstrated a positive commitment to improve fire safety, this was reactive and not proactive risk management and we were concerned that audits had not highlighted and resolved these issues prior to our visit. These findings demonstrated that the registered persons had failed to adequately monitor and reduce risks relating to health, safety and welfare of people who used the service.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our concerns regarding fire safety with the local fire officer who visited and planned to return.

During our observations we identified unmarked ramps in corridors. These posed a tripping hazard for

people at an increased risk of falls. Records seen did not indicate falls had occurred on the ramps in corridors. However, the risk to people's health and safety had not been mitigated. On the first floor we found two fire doors that did not close properly to their rebates, which posed an accident and injury risk. Doors that had coded locks to prevent people accessing the area such as the sluice and the kitchenette were open. The door to one bathroom was open. This room was being used to store commodes and other items and posed a safety risk.

Throughout the inspection, we identified issues with the cleanliness of the service. One person who used the service told us, "The home could do with a good scrub. I know it's old, but it could be cleaner." We found significant shortfalls in relation to infection control. For example, some pillows were without wipeable covers and were visibly stained. Some mattresses did not have a waterproof covers. This meant they were exposed to contamination and prevented adequate cleaning. Some mattresses were stained with what appeared to be urine and faeces. Sofa and chair cushions were also dirty. These concerns represented a cross contamination risk and showed the provider had not maintained a clean and appropriate environment which facilitated the prevention and control of infections as is required under Criterion 2 of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

The Community Infection Prevention and Control Nurse Specialists who supported our inspection made 12 recommendations for improvements. These findings demonstrate the registered persons had failed to assess and mitigate the risks to the health and safety of people living at the service.

We spoke with the manager and regional manager about the infection control findings and they arranged for areas of the service to be deep cleaned. They also told us additional audits would be completed to monitor infection prevention and control practices.

The administration of medicines was not consistently safe. For example, we found staff had not followed advice from a community nurse with regards to a person's end of life medicine. The community nurse had not been contacted when a device, used to administer medicine, stopped working. This meant the person did not receive their prescribed medicine. The manager was made aware of this during our inspection and took steps to prevent this happening again.

Where necessary, medicines were stored in a fridge. However, checks were not consistently recorded to evidence that the temperature the medicines were stored at remained within safe limits.

Some people were prescribed medicines to be administered 'when required'. The provider's policy relating to this stated that 'Medication Protocol Forms' should be completed when these medicines were administered. Whilst these forms were in the file, it was evident staff were not completing them. For example, one person was given a regular evening dose of a PRN medication, but it was not recorded on the protocol form. This meant that an accurate record of medicines administered was not maintained.

We saw 'Transdermal Patches' were used for medicines that are administered through the skin. However, staff had not consistently recorded where on a person's body they had sited these patches. This is necessary because the application site needs to be rotated to minimise the risk of people developing problems with their skin integrity.

The provider had a 'Homely Remedy Policy' which listed medicines staff could administer without a prescription such as Paracetamol and Aspirin. However, we found the service had not made appropriate arrangements for people in the service to receive homely medicines.

We observed that the key to the CD cupboard was not held separately from the other medicines keys, which went against the provider's policy guidance. We found that some 'out of use' CDs were not being stored within the CD cupboard.

We shared our concerns in relation to medicines arrangements with the manager and they agreed to look into them.

We concluded that the provider had not done all that was reasonably practicable to manage infection prevention and control risk and ensure that medicines were managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People who used the service were identifiable by a photograph of them in front of their individual Medicines Administration Record (MAR). This reduced the risk of medicines being given to the wrong person. Controlled drugs (CDs) were recorded correctly. CDs are medicines which require strict legal controls to be applied to prevent them being misused, obtained illegally or causing harm.

People who used the service had long term conditions relating to their physical frailty and mental health needs. Before we visited, relatives and professionals had raised concerns that not all of the needs relating to these conditions were being met because of the number of agency staff on duty. During the inspection, we found the reliance on agency staff was having a negative impact on the quality of people's experience of living at the service.

One person we spoke with said, "My care is ok the staff do try hard, but I cannot see how things can improve all the time they are overworked. Some agency staff do not do a lot." A health professional told us, "Some staff appear to be at their wit's end and some staff appear out of their depth."

At this inspection, we found staff recruitment and retention difficulties had an on-going impact on people's care and the ability of the manager to bring about the necessary improvements.

The provider used a dependency tool to determine appropriate staffing levels. This took into account the number of people who used the service and people's needs. We saw the provider used agency staff, where necessary to cover gaps in the rotas.

During the first two days of our inspection, we saw people who required support were not assisted in a timely manner. For example, we heard one person regularly calling out for attention. They told us they often had to wait for staff to help them. On a number of occasions we intervened to ask staff to assist people because they were becoming distressed. A number of people required two staff to assist them with their personal care and we observed this left people unsupervised for periods of time including people who were assessed as being at high risk of falls. We observed six people on the dementia care unit were left unsupervised over a full mealtime while staff supported people in their bedrooms. This meant that staff were not always available to ensure people who were at risk of poor nutrition received an adequate food intake and to encourage social interaction. Staff told us they did not have time to attend to people as promptly as they would like.

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

On our third day of our inspection we noted that improvements had been made and we observed staff were

readily available to meet people's needs.

We looked at the recruitment process and examined three permanent staff files and found that all necessary checks had been completed.

Accidents were recorded appropriately. We saw evidence that a monthly accident audit had been completed which reviewed the control measures which had been put in place to reduce the risks of a reoccurrence.

The service has a safeguarding and whistleblowing policy. Whistleblowing is where people can disclose concerns they have about any part of the service where they feel dangerous, illegal or improper activity is happening. Staff told us they had received training on safeguarding and they knew what actions to take to safeguard people from abuse and how to report abuse.

Requires Improvement

Is the service effective?

Our findings

On the first day of our inspection, we observed the lunchtime experience in the unit for people living with dementia. We saw people were left unsupervised after their meal was served with the result that they did not receive the support to eat and drink they needed. For example, we saw one person looking around after they had eaten part of their meal. They then moved away from the table, because staff were not on hand to offer them encouragement to complete their meal. We also observed some positive examples where staff prompted and encouraged people to ensure they ate and drank enough. However, we were concerned about the inconsistencies we observed in the care and support provided at mealtimes.

There were mixed comments from people who used the service about the quality of the food. We saw correspondence from the manager to the food safety manager in June 2017. This highlighted concerns that the previous chef was not providing good quality food choices. Relatives told us they felt the quality of the food had recently improved. One relative told us, "The residents have more choice other than just sandwiches on an evening now." We observed the chef speaking to people about their food choices.

We reviewed people's care files and saw that people were regularly weighed. We saw that care plans were reviewed monthly to monitor issues and concerns regarding people's weight loss.

We checked the profiles and induction records of four agency care workers. There was no profile in place for the member of agency staff who was on duty on the first day of our inspection. We found other examples where agency staff had worked without evidence that they had received an appropriate induction. The manager and the regional manager confirmed that inductions and profiling information for agency staff had not been completed. This meant that the provider could not ensure staff had the necessary skills and information to work safely.

The regional manager took action on the third day of our inspection to ensure that all inductions would be completed and a new agency staff file would put in place.

We received different views from staff about the frequency of their supervision and appraisal. Supervision and appraisal is a process, usually a meeting, by which an organisation provide guidance and support to staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice. Records showed there were gaps in people's supervisions, especially when the manager was on extended leave.

We identified concerns that agency staff had not received an appropriate induction before working at the service. Staff did not consistently receive the support, professional development and effective supervision and appraisal they needed to enable them to effectively carry out the duties they were employed to perform. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had access to a range of e-learning. The manager showed us a training matrix which they used to monitor courses completed and when training needed to be updated. We were shown evidence of action taken when training had not been completed. Records evidenced staff were given warning letters and then were seen by the manager if they did not complete the training required.

The manager and a senior care worker had completed a two day specialist course (Dementia Care Framework) to understand the needs of people living with dementia. The manager told us that all the staff were going to receive this training. This demonstrated a commitment to understanding the needs of people living with dementia.

We found the premises did not reflect good practice in design for people with dementia to help them understand their environment and promote their wellbeing. Corridors and rooms such as toilets and bathrooms were not signposted in a way that people with dementia could understand and to help them navigate their way around. Furniture in the communal areas was being used to store bedding and files so their contents did not help to encourage people's interest or stimulate conversation. Although the service had communal gardens and outside areas, these were not secure so were not suitable for people who may be living with dementia to independently explore.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found the provider was taking appropriate actions to protect people's rights. We saw that applications had been submitted, where necessary, to deprive people of their liberty. Staff were aware of people's right to refuse support and respected people's decisions.

We saw a member of staff speaking with a person who was chewing their Paracetamol tablet rather than swallowing it. The person consented to their GP being contacted to discuss the possibility of having their medicine in a syrup form to make it easier to swallow. This demonstrated that the member of staff was effective in noticing a change in this person's health needs and sought their consent to taking action on their behalf.

Relatives told us people who used the service had access to healthcare professionals. One relative said, "Doctors' visits are arranged quickly." Another explained staff had acted promptly and advocated on behalf of their relative when a doctor was asked to see them again. A health professional confirmed that staff contacted them regularly for advice. Care plans recorded details about people's health needs and referrals made to address health concerns.

Requires Improvement

Is the service caring?

Our findings

We saw examples where staff showed kindness and were caring towards people who used the service. We observed staff speaking with people in a gentle and patient way demonstrating that they cared about the people they supported. A healthcare professional told us, "I see some very happy residents and carers being lovely."

Although we observed a number of kind and caring interactions, we saw staff did not always maintain people's privacy and dignity. For example, we walked passed one person's room and saw their door was propped open whilst they were sitting on a commode. We requested the person's door was closed to protect their dignity and staff responded to our prompts. However, we saw other people were laid on their beds, in various states of undress, with their bedroom door open. We observed that staff made no effort to close their doors or cover people to protect their dignity.

We observed staff on the ground floor residential area did not always respond to people who were distressed and calling out for help. When we intervened to ask staff to help people, we found they were willing, kind and supportive. However, we were concerned that staff had not been proactive in responding to people who were clearly distressed or required help. The regional manager later told us they had discussed our concerns with staff and had requested specific dignity and respect training for all staff.

On the unit for people living with dementia, we saw both positive and negative examples of care and support for people. We saw some staff were attentive and spoke kindly with people. Others were busy with physical tasks and did not spend time with people on an individual basis. On the first and second day of our inspection, we observed several people appeared dishevelled and two people had no socks or shoes on. One person had dirty nails and another was wearing stained clothing. On our third day of inspection, we found people were well dressed and groomed. Although people did not raise specific concerns with us regarding lack of personal care, we were concerned about these inconsistencies in the care and support we observed during the course of our inspection.

On our third day of inspection, we found there was appropriate music playing in the background and the atmosphere was calm. Three members of staff were available to assist people with their lunch. We observed the staff sharing a joke and being interested in what people were doing and what they were saying. We noticed more people were in the residential unit. One person was getting individual attention. The member of staff was asking them what they wanted to do. The person wanted to listen to the radio and was offered choice of which station to listen to. They were also offered a choice of drinks. The member of staff showed kindness and warmth to this person.

We received mixed feedback about the staff working at Clover House Care Home. Relatives spoke highly of the senior staff. One relative told us the seniors "were lovely." Another relative said, "There are lovely staff here, can't praise them enough, but staff are stretched to the limit." A relative we spoke with said, "The staff were kind and caring and talked to [Name] nicely and had a good chat."

Requires Improvement

Is the service responsive?

Our findings

When we spoke with the care staff we found they lacked understanding about how positive support could be effectively used to guide people's care and promote their emotional wellbeing and safety. We observed one person was frequently anxious and upset. Staff told us the agreed strategy was to encourage the person to socialise and this helped to reduce their anxiety and distress. Although we observed short periods of time when the person was brought into a communal area, the person spent the majority of the time on their own in their room.

It was evident from our discussions with the senior care staff that they knew people who lived at the service well and GPs and visiting healthcare professionals reported having confidence in them. Relatives were complimentary about the senior care staff and other members of the permanent staff team. Relatives of a family who were visiting a person who was very poorly were very complimentary and described one of the care workers as "fantastic". However, they were not confident that all of the agency staff had the necessary skills or commitment to care for their loved one. A member of staff told us, "It is difficult working with agency staff as they don't know the residents as well as I do."

We saw that people's care plans were not always clear and were not being followed in practice. For example, one person's care plan stated they needed a high level of observation and support. The monthly accident report for May 2017 recorded numerous falls for this person and stated hourly checks were in place. We saw from the person's records that observation checks were not always completed in line with their care plan. For example, over a one week period in July 2017 no checks were recorded for three days. The form was not clear about the timing of the checks and entries varied making it difficult to ascertain the precise checks being made. The manager told us this person had their medicines reviewed and they now had hourly checks through the night.

We observed gaps in people's observation and repositioning charts and in daily records. For example, 30 minute observations on a person with high needs were not being recorded.

During the inspection, we reviewed the support available for people who used the service to engage in meaningful activities. People we spoke with told us they had repeatedly raised issues about the lack of meaningful activities at the service. Staff meeting minutes from 5 January 2017 documented that people and their relatives were very unhappy about the lack of activities. We saw a 'relative's meeting' had been held in April 2017, during which the manager acknowledged that the lack of activities had been an area of concern for a long time. Minutes from this meeting showed the manager had shared the plans they were putting in place to address these concerns. This included seeking suggestions and feedback from people who used the service on how the activities could be improved. However, our findings showed us more work was needed to improve the support provided for people to engage in meaningful activities.

When we inspected the service people told us, "We need more to do, it is really boring here", "Staff never sit and talk to us" and "I used to enjoy gardening. Now I sit or try and walk around the care home. I want to do more than watch TV." During our inspection, we observed that two 'pat dogs' had been brought to the

service and people enjoyed seeing them. However, outside of this, we observed staff spent long periods of the day engaged in practical tasks with limited support available for activities to inspire people or evoke any memories or emotions. For one person, we saw that their interests included reading the newspapers, drawing, being creative, cleaning and helping out. From their records the person had not been supported to follow any of their chosen activities in the past month. A new activities organiser had been appointed, but they lacked the necessary resources to demonstrate an appropriate level of stimulation and activity. We saw group activities did not take into account people individual likes and preferences. For example, people who used the service told us they were interested in doing more craft based activities, rather than, for example, bingo which was not always popular.

We received mixed feedback with regards to how people wanted to be cared for. For example, one person told us they had specifically asked for female carers to undertake personal care and this had been respected. Other people who used the service said, "I expect my son had talked about my care, but I can still think for myself so would like to be involved" and "I would like more choice for food, clothes and support, but have to take it when I can get it."

This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy and procedure in place to govern how they would manage and respond to complaints about the service. The majority of people who used the service that we spoke with told us they would complain to their care worker as they were not sure who the manager was or told us they did not feel confident speaking to people 'higher up'. We saw that the manager had met with people who used the service to share information about how to raise concerns and encourage people to provide feedback.

Relatives we spoke with told us they knew who the manager was and had spoken with them when they had issues or concerns. Staff said they tried to do what they could and reported any concerns to the manager and in the handover sheet, so that staff were aware of the issues. We saw evidence that the manager and regional manager had met with people who raised concerns to try and resolve issues and improve the service provided.

Requires Improvement

Is the service well-led?

Our findings

At this inspection, we identified a number of concerns and breaches of legislation. These related to safe care and treatment, good governance, staffing and person centred care. There had been a number of different managers since our last inspection and this had impacted on the quality and consistency of the care provided. Staff told us standards had deteriorated since the last registered manager had left and they had struggled to provide the standard of care they would wish for. People who used the service commented, "This place used to be really good, but it has gone downhill over the last year" and "The service had lost its way." People we spoke with raised concerns about staff being very busy, the lack of meaningful stimulation and activities and that there were not always enough staff to support them.

At the time of our inspection, the most recently appointed manager had returned from a period of extended leave. The manager had identified improvements they planned to make, but we found these were at an early stage of development and had not always addressed the issues we identified. For example, the manager told us about new chairs that had been purchased. However, we found these had not been cleaned and were dirty.

The provider's policies and procedures were not always followed and audit processes had failed to identify issues we picked up on such as inconsistent recording. We found that risks to people's health and wellbeing were not being well managed. Staff had not always followed people's care plans to ensure that action was taken to reduce the risks that were identified.

The provider's systems in place to monitor the quality of the service and drive improvement were not effective. For example, the minutes of a Quality Clinical Governance Meeting held at the service in January 2017 included feedback from a resident survey regarding poor cleanliness. It was recognised that standards needed improving and action would be taken. However, our inspection identified on-going issues with the cleanliness of the service and with infection prevention and control practices. We saw regular infection control audits had been completed, but these had been ineffective in ensuring the service was clean. On the third day of our inspection, the regional manager had put plans in place to commence a deep clean of the service and a team of four cleaners were present throughout the day. Whilst this demonstrated a positive commitment to improve the quality of the service provided, it was evidence of reactive not proactive management.

The PIR did not tell us how many monitoring visits had been made by senior managers or internal quality auditors to the service to assess the quality of care provision within the last 12 months. Although additional support had been provided from the provider's 'resident experience' support managers, it was not clear what impact this had on improved outcomes for people who used the service. These visits had not been effective in identifying and addressing some of the issues we observed.

In their PIR, the provider told us they had received one complaint through the formal complaint procedure. When we spoke with people who used the service, relatives and staff, they referred to other complaints, which had been managed outside the formal complaints system. This meant that the wider organisation did

not have an accurate picture of the concerns that were being raised and could not monitor the service effectively for any emerging themes.

Our findings show that this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

Staff said the manager and the regional manager were approachable and were confident that they listened and acted upon any concerns raised with them.

Not everyone we spoke with knew who the manager was. However, one relative thought that the manager was leading better than the previous managers. They told us, "[Name] is visible. I am happier now that they have got a grip and are beginning to steady the rudder." Another relative told us, "They have listened to what we were saying and I think they will act."

People were encouraged to give feedback and the manager displayed what action had been taken in response. For example, on the notice board in the entrance the manager had put up the results of the surveys and the action to be taken. Minutes of a relative's meeting held in April 2017 indicated the manager's commitment to listen and act on concerns raised. An entry read, "I welcome your feedback and I want to make this place great again, so please tell me if you have any issues, good or bad."

Relatives told us they had raised concerns regarding the quality of the care provided by agency staff and felt both the regional manager and manager had listened to them. These relatives felt slightly more confident that the standard of care had improved over the duration of our inspection.

The service's PIR stated, 'trends identified are that of excellent, high quality care.' However, the feedback we received from people who used the service, relatives, staff and healthcare professionals, was not positive about the agency staff. One relative told us, "The agency staff are not as good as the permanent staff." Another told us, "There are too many agency staff."

We observed that the permanent senior care worker knew their way around people's medicine records, but the files in which the MAR charts where kept were untidy. This means that agency staff, not used to working at the service would find it more difficult to access information easily.

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 Care or treatment had not been designed with a view to achieving service users' preferences and ensuring their needs were met. Regulation 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users receiving care had not been addressed and all that was reasonably practicable had not been done to mitigate any such risks. Regulation 12 (2)(d)(g)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes had not been operated to assess, monitor and improve the quality and safety of the service provided and to mitigate risks relating to the health, safety and welfare of service users. Regulation 17 (2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Appropriate checks had not been completed to ensure agency staff were suitably qualified. Staff had not received regular supervision and appraisals. Regulation 18(1)(2)(a)