Avante Care and Support Limited

Bridge Haven

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**

Overall summary

The inspection was carried out on the 14 & 15 July 2015 and was unannounced. A previous inspection on 1 September 2014 found shortfalls in regards to record keeping. We asked the provider to take action to make improvements to record keeping in the service and they sent us an action plan that stated the provider would meet their legal requirements by 28 November 2014, but this action has not been completed.

Bridge Haven provides accommodation and personal care for up to 53 people living with dementia. At the time of our inspection there were 35 people living in the service. Accommodation is provided on one level and this is divided into two units 'Primrose' and 'Bluebell', one unit accommodates 29 people and one unit accommodates 24 people. Separate lounge and dining areas are provided for each unit but the open plan nature of the premises means that people can move easily between these areas. The premises are well equipped with plenty of equipment and bathing facilities. People have access to garden areas that are secure and easily accessible; a cabin in the grounds serves as a small tea shop where people can go with their relatives or with staff to have tea and coffee. The service is located in a residential location providing easy access to shops and public transport.

Summary of findings

This service has not had a registered manager in post since October 2014; interim management arrangements were in place with additional support provided by senior managers. A registered manager is a person who is 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.

This inspection showed that people were not always safe and did not always get their needs met.This was because there were insufficient staff on duty to meet their needs and provide the assistance they needed.

Staff lacked a clear understanding of abuse and how to respond and report this appropriately; this placed people at risk of some incidents not being responded to consistently. Staff showed a lack of awareness in their everyday practice to health and safety hazards that could place people at risk of harm. Some important information about risks had not been developed in people's care plans that would help staff recognise the signs and triggers they should be aware of to ensure they implemented the necessary risk reduction measures.

Information provided to inform staff in relation to emergency evacuation of the premises needed improvement to ensure staff knew what action to take and what equipment to use in the event of an evacuation of the premises, and what arrangements were in place for business continuity.

People and staff were at risk because guidance was not available to inform staff how to support people with behaviour that could be challenging. Records were not always well completed across a range of documentation and care plans did not always accurately reflect the support people were receiving.

CQC is required to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The assistant manager showed she understood the responsibilities of the service to seek authorisations for people who may need some restrictions placed on their liberty. However judgements made by staff about people's capacity to undertake everyday tasks or make decisions for themselves was poorly recorded within care plans to support their practice.

There was a low level of incidents recorded but these did not always include incidents recorded as part of behaviour monitoring, there was therefore a risk of under reporting of the number and range of incidents.

People left meals untouched because staff were not there to give them the prompting and encouragement they needed to stay and eat their food. The premises did not meet the needs of people living with dementia and there was a lack of signage to help them navigate their way around the home. The standard of cleanliness was not always to a good standard and equipment was not stored hygienically.

People were not provided with information about meals or activities in a format that was suitable to their needs or helped them make informed choices. The provider could not assure themselves that staff had the right knowledge and skills to deliver safe quality care to agreed policies and procedures because staff training was not up to date, there was a lack of assessment of staff competency and staff did not receive regular supervision. Improvements in staff competency for the administration of medicines were not sustained with a number of recurring medicine errors that could place people at risk of harm.

People were not provided with activities that met their needs. Relatives were given opportunities to express their views but did not feel their concerns were acted upon. People were at risk because the provider did not have an adequate system in place to assess and monitor the quality of care and treatment people received and to identify and act on shortfalls.

Staff said they felt supported and confident of raising issues with the assistant manager. They told us they had regular staff meetings to share information. New staff were provided with an induction that was in line with the requirements of the new care certificate. The required checks were carried out on staff before they commenced work.

People were supported to access healthcare for routine and specialist health care support, and records showed regular visits from GP's and community nursing staff.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of this report.

Summary of findings

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 safe.

Staffing levels were insufficient to provide people with a safe level of care and support. Health and safety hazards to people were not always identified by staff and this placed people at risk. Care plan risk reduction measures were not always implemented. Not all staff demonstrated an understanding of safeguarding and the protection of adults or the role of other agencies and there was evidence of under reporting People were at risk because equipment was not always stored appropriately in clean and hygienic areas.

Emergency plans lacked detail about evacuation equipment to be used and plans for business continuity. Medicines were not always administered safely by staff, and more information was needed around the rationale for administration of 'as required' medicines.

The premises was maintained and checks of gas and electrical installations were routinely made in addition to regular servicing checks of equipment to ensure this was in good working order. Comprehensive checks were made of new staff before they were employed.

Is the service effective?

Requires improvement

The service was not always effective

Staff training was not updated and staff competencies were not assessed to ensure they had the skills to undertake their role safely. Recording of how decisions were made about capacity and how consent was gained was poor. There was a lack of guidance to inform staff how to work with people whose behaviour challenged the service.

Information provided to people about meal choices was not in suitable formats, and not everyone got the assistance they needed when they needed it. Recording of food and fluid intake for people at risk was inconsistent. There was a lack of signage and prompts to help people get around.

The principles of the Mental Capacity Act 2005 were not fully implemented in the everyday practice of staff, with regard to gaining consent and the assessment of people's capacity. New staff received an induction to their role that gave them the basic skills they needed before commencing work. People's healthcare needs were met.

Is the service caring?

Requires improvement

The service was not always caring.

Summary of findings

Staff lacked awareness which could compromise people's dignity. Some care support arrangements were not always recorded. People sometimes needed more support than was provided and staff were not able to spend time with them.

Information was available but not in suitable formats for the people using the service.

Personal care was delivered how people wanted it and their privacy and dignity was respected in most cases. Relatives said they were kept informed of events that happened to their relative but not always in relation to specific care arrangements. They said they were always made welcome by staff.

Is the service responsive?

Requires improvement

The service was not always responsive

An activities programme was in place but there was a lack of regular meaningful activity and stimulation for people.

Important guidance for staff about people's health conditions or behaviour was absent form care plans. Care plans were updated but not always reflective of current needs or care practice.

Not all the concerns people raised were recorded. There was a lack of confidence that issues raised were acted upon.

Is the service well-led?

Requires improvement

The service was not consistently well led.

A registered manager had not been in post since October 2014. Interim management arrangements were in place, but were not effective.

There was under-reporting of incidents, and there was a lack of analysis of these and behaviour monitoring records. Record keeping needed improvement in a number of areas. Audits undertaken by the management team were not implemented effectively to pick up shortfalls.

People, relatives and staff said the assistant manager was friendly and approachable. Staff felt communication was good. There were opportunities for staff and relatives to express their views at meetings.

Bridge Haven

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 14 & 15 July 2015 and was unannounced. The inspection was conducted by two inspectors, and a specialist advisor (a specialist advisor is a health or social care professional who has experience relevant to this type of service).

Prior to the inspection, we looked at information we held about the service and notifications we had received about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

People in the service were living with dementia and could not tell us about their experiences of living at the service. 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 to us. We 'pathway tracked' five of the people living at the home. This is when we looked at people's care documentation in depth. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also observed care provided to people throughout the inspection, including mealtimes. We spoke with seven people's relatives during and after the inspection to ask them for their views about the service.

We spoke with eight care staff, one activities staff, and two staff from the domestic team and catering teams, in addition to the new manager, assistant manager and a regional manager.

During the inspection we viewed a number of records including seven care plans, four staff recruitment records, and records of staff training, supervision and induction information. We looked at arrangements for staff support, and policy and procedure information. We reviewed incident and accident information and complaints and compliments, health and safety information risk assessments, menus and quality assurance information.

Requires improvement

Is the service safe?

Our findings

People were calm and relaxed with each other and staff. Three relatives commented positively about different aspects of the service, and were satisfied that their own relative was safe they felt there were enough staff. One relative commented "it's always buzzing, always staff around, they have a strong core of staff so faces are always familiar".

For daytime shifts one unit for 24 people was supported by one team leader and three care staff and the second unit for 29 people was supported by a team leader and four care staff, although divided into two units these were open and people could walk into and use the communal spaces in either unit if they wished to do so. Individual dependency assessments were not completed and the provider could not accurately calculate the level of support individual people needed and therefore the overall numbers of staff required. A recent escalation in safeguarding alerts had resulted in admissions from the local authority being on hold, there were therefore a reduced number of people in the service. Our observations at inspection showed that even with this reduced number of people there remained issues with the effective deployment of staff during the day and the sufficiency of staff at peak times, for example meal times.

At meal times there were insufficient staff to provide the wide range of assistance people needed to ensure they sat and ate their meals. As a result people were seen to wander off leaving food unattended and uneaten. We also observed an example of where the lack of staff availability resulted in a staff member supporting two people with different needs, These could not be adequately met without one person's needs being prioritised over another, and for example a person needing assistance with a meal was left so that support could be given to someone in danger of falling.

At lunchtime we observed that there was no clear system in place for delivery of meals with some people observed eating pudding whilst others were just receiving their soup. Some people left their soup to go cold, or left their meal because there was not enough staff available to assist, prompt or encourage them to eat. People were given a choice of where to eat their meals but given the spread of the floor area this made it difficult for staff to oversee. At one point we observed all the meals for one unit were left on the counter unattended and uncovered. The meals were all the same and we saw no one with an alternative meal. Most people were not able to express their views about the quality of food but one person when asked screwed their face up and said, "It would have been nice to have something hot". People were not particularly interested in the food and a number wandered off and left their soup or meal. We did not see adapted crockery or cutlery in use to assist people with maintaining a level of independence with their meals.

The lack of staff presence in communal areas all day posed a risk that incidents between people and, people falling, could occur unwitnessed. At inspection a person who was assessed at risk of falling fell in an area between the lounges and outside of the kitchen serving hatch. No one witnessed the fall although staff arrived soon after and acted quickly to get the right intervention for the person. Another person assessed at high risk of falling was able to walk from one end of a unit to another without their walking aid before staff were present, noticed and intervened before the person fell.

The nurse call system worked well but most people were unable to summon help for themselves when in their own rooms. People were not routinely checked during the day unless they were deemed to be at specific risk. The lack of sufficient staff could lead to people being left unattended when in their rooms, as they could not summon help if they were unwell or had fallen.

There was a failure to ensure sufficient, skilled staff were available to support people safely at all times to ensure they were provided with an appropriate level of assistance. This is a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had received training in infection control; they had access to supplies of personal protective clothing and were observed using these. Cleaners were visible throughout the inspection and cleaning schedules were in place. Visibly the service looked clean and there were no obvious odours. However, our observations showed that the cleaning of bathrooms and toilets needed improvement because we found dried faeces under a clinical waste bin in one toilet where the floor beneath this had not been cleaned, a dried half eaten sandwich in the same toilet, and dried faeces smeared on a handrail near to another toilet. This posed a risk to people using those areas but also because spare equipment for example walking frames and

Is the service safe?

wheelchairs were found stored in bathroom/toilet areas that were used by people on a daily basis. Staff did not acknowledge to us that they found this a problem, nor had staff reported this as an issue to senior management. We were not therefore confident that staff had an understanding that there was a risk of cross infection from people using the facilities and touching the equipment being stored in these locations. There was no protocol for ensuring the equipment taken from these areas was cleaned prior to use.

Each person had a personal evacuation plan (PEEP) which staff were aware of, but this did not make clear how staff were to effect a quick evacuation with what equipment. No specialist equipment had been installed that staff could access and they had not been given specific training around this. There was a risk that in an emergency requiring evacuation staff would not have all the necessary information and equipment they needed, to enable them to evacuate people safely. A business continuity plan had not been developed in the event the service had to stop suddenly through emergency, and where people might go if the period of closure was longer than a few hours.

No contingency plan had been developed for adverse weather conditions or wide spread illness amongst staff or, when the nearby school listed as a place of safety in the event of an emergency was closed for school holidays. This showed the service had not fully considered how they would provide continuous care to people in the case of one of these emergencies.

There was a failure to ensure that bathroom and toilet areas were kept clean and that equipment was stored appropriately and maintained in a clean condition. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received health and safety training, but their day to day practice showed a lack of awareness around health and safety matters, and this could impact on people's safety. For example in a patio area used regularly by people we found a large garden fork that could pose a risk to people who might be unsupervised. We found an exposed hot pipe in a toilet frequently used by people. These matters were addressed once these had been pointed out to staff but there was a concern that staff had been unable to identify these risks for themselves and this lack of understanding about potential risks posed a risk to people's safety.

Each person's care plan contained individual risk assessments relating to for example, skin integrity, falls, and nutritional risks. These guided and informed staff about the controls that needed to be in place to lower the potential for harm to occur by ensuring they for example used the right equipment or provided the right level of staff support. Some important risk information however, was missing, and this placed people at risk of not receiving the appropriate level of support to reduce risks to their wellbeing. For example, there was a lack of guidance to inform staff about the risk posed by some people's behaviour, or their mental wellbeing, Staff were not provided with information about the signs and triggers that could alert them to take action, and the control measures in place to lower the risk of incidents occurring.

People were at risk because staff had not acted in accordance with care plan risks. For example in the care plan of someone who walked about at night, sometimes into other peoples rooms, the agreed risk reduction measure was the installation of an alarm mat in their room. This would alert staff when the person was out of their bed and therefore needed monitoring. We checked the person's bedroom to ensure the mat was in place and in working order, we found there was no alarm mat there and staff told us this had not been there for some time, it was not made clear within the care plan whether the risk had diminished and the mat was no longer needed.

There was a failure to ensure that risks were managed appropriately. This is a breach of Regulation 12(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two experienced care staff told us that they had received safeguarding training. They said they knew where they could access policies but when asked were unable to demonstrate they had sufficient knowledge of what safeguarding adults meant in practice. They were unable to tell us how and to who they would report their concerns to outside of the service and organisation, as there was further evidence in daily notes that staff were still under reporting some incidents and failing to recognise those that may need to be alerted through the safeguarding reporting processes. There was therefore a risk that some staff may not recognise abuse or take appropriate steps to report it

Requires improvement

Is the service safe?

The failure to ensure that staff had a clear understanding of their responsibilities to safeguard people from harm is a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were not managed safely because errors continued to occur. Investigations of the causes of medicine errors since the change to the medicine management system indicated the reasons were mainly due to the competency of administering staff, not because of problems with the administering system. We observed staff administering lunchtime medicines and this was managed appropriately. No medicines were administered covertly (this is where people are unaware that medicines have been placed in their food or drink) Individual guidance was available to inform administering staff about the administration of 'as required' medicines for some people. However, this information lacked detail to inform staff about the signs and symptoms they should look for in people who might not be able to tell them their need for these medicines. This information would help inform staff decisions to administer or not, and aid consistency in administration.

The failure to ensure medicines are managed safely is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements for ordering, receipt, storage and disposal of medicines and found these to be completed satisfactorily. Only staff that had completed a 12 week medicine course and were assessed as competent were able to administer medicines; their competency was reassessed annually. Medicine Administration Records viewed were completed appropriately and any changes signed and dated for.

A new staff member told us that they had completed an application form and attended for interview before coming to work at the service. Before they were able to take up their post checks of their suitability were made. Recruitment files viewed showed that applicants previous work history and conduct in employment and character references, were obtained in addition to evidence of personal identification, and a current criminal record check using the Disclosure and Barring Service was obtained prior to the person taking up post.

Appropriate arrangements were in place for the ongoing maintenance and repair of the premises.

Up-to-date certification was seen for equipment in use throughout the home: this included hoists, stand aids and baths. A maintenance book showed that staff were reporting the majority of repairs'

Requires improvement

Is the service effective?

Our findings

Relatives told us they felt well informed about their relative's health needs and care. Two relatives commented on people being left with food in front of them and not receiving support or prompting form staff to eat. Other relatives thought the quality of food was good. One said about the person they visited "He eats well, and can have as much as he wants, the food is very good".

The service had recently admitted people with behaviour they could not support appropriately. Staff told us that they had not received the necessary training to inform them how to work positively with people with such needs. There was a lack of guidance available to inform staff who said they were simply "Acting on gut instinct", in the way they responded.

We looked at the care plans for two people whose verbal and physical behaviour could sometimes be aggressive, but information about triggers to their behaviour, how it manifested and how it should be supported was absent. People were at risk because staff support was not guided by agreed strategies to manage each person's behaviour. Behaviour monitoring records were not always completed to provide an accurate picture of the level and frequency of some people's behaviours. Antecedent Behaviour and Consequences (ABC) forms which should be used to document behaviours were blank on recent charts, although daily records for the same period showed a number of incidents had occurred for each person.

There was a failure to ensure detailed and accurate records were maintained of people's assessed care, treatment and support needs so staff were provided with current information and guidance, so that care could be provided appropriately and consistently. This is a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training to understand the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. However, records showed recording about how capacity decisions were made for individuals was poor, For example judgements had been made about whether people could manage their own medicines or undertake aspects of their personal care, but how these assessments and judgements had been made was not recorded to support staff practice.

Staff lacked an understanding that some everyday practices they carried out were not in keeping with the principles of the MCA. For example, in several care plans we looked at we noted night time arrangements included a statement that people could agree or not agree to have their bedroom doors locked at night. We were informed that this was an historical arrangement put in place some while ago following specific concerns about room incursions by other people in the service, this practice had been continued with ever since. Whilst some people could open their bedroom door quite easily from the inside if they wanted to, other people could not. The new manager stopped this practice immediately and planned to consult relatives individually about their concerns.

The assistant manager was aware of the requirement to refer people to the local DoLS team to seek standard authorisations for all the people in the service who required 24 hour supervision, lacked capacity to understand this and could not leave the building of their own free will, records showed action had been taken to ensure everyone who met the criteria was referred.

Staff told us that they considered people's consent on a daily basis and for specific issues and made an 'assumption of capacity'. When people failed to give a response but were happy for staff to continue with support, staff said they anticipated the decision the person was likely to have made for themselves. This was based on information that had been gathered about the person's preferences from feedback from relatives or people who knew them well, and through knowledge staff had gained of the person. This was not always recorded in people's daily notes. For example on three files we noted that consent to care, treatment and use of photos was recorded by relatives on the persons behalf. However, on the care plan of someone without capacity who had bed rails in place no consent was recorded.

There was a failure to ensure that people's capacity to consent was assessed and their consent to care and

treatment was supported appropriately within the everyday practice of staff. This is a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A menu was written up every day on a board facing into the lounge areas and this took account of peoples individual dietary needs. Staff reported most people were no longer able to absorb and understand written information but a pictorial version was not available to help them make food choices.

Nutritional assessments were completed for people when they came into the home. Special diets were catered for and people at risk of choking were provided with soft, pureed or liquidised meals dependent on their requirements. Measures were implemented to ensure those assessed as 'at risk' ate and drank enough. Records showed that people were maintaining or gaining weight. However, there was a risk that shortfalls in staff recording of fluid intake could fail to alert them if people were not drinking enough or that their outputs level signalled any cause for concern around their health.

Staff told us their training was up to date and they were routinely reminded when their specific training updates were due. Records showed there was an established training programme to provide staff with updates of essential skills training, for example, moving and handling, first aid, fire training, safeguarding adults training, infection control and food hygiene, and awareness of dementia. However, the system for updating staff training was not working well. Staff were shown as not having completed some training at all and others were overdue updates to ensure their practice remained current, for example 12 staff had never completed first aid training. There was a risk that people might be supported by staff lacking current knowledge and skills to respond to incidents appropriately and safely.

From the shortfalls we have identified in respect of staff awareness of health and safety issues, implementation of safeguarding, infection control and mental capacity, there is a concern that the quality of training provided and the assessment of individual staff competency needs review to provide assurance that staff knowledge and skills was appropriate and embedded in everyday practice.

There was a failure to ensure that staff had the right knowledge, skills and competencies to support people's care and treatment appropriately. This is a breach of Regulation 18 (1) (2) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

New staff received a three day external induction that included an introduction to the company and training in the basic essential skills they would need to support people appropriately once they commenced work. Staff were given time to familiarise themselves with people's care plans and policies and procedures. Staff completed short workbooks in respect of essential training they had received to ensure they had understood what they had learned. The provider was involved in the pilot for the new Care Certificate and staff induction at the service had been amended to meet part one of the certificate.

Staff said they received one to one formal supervision with their supervisor where they could raise issues affecting their role. Supervision schedules showed these were less frequent than company policy required but staff said they did feel supported and could speak to the assistant manager or team leaders anytime.

Adjustments had not been made to ensure the environment was suitable for people with dementia, for example, the type of décor, the use of colours and type of flooring that have been shown to be of benefit to people living with dementia. There was a lack of appropriate signage or visual aids to help people navigate their way around the premises. For example, an entry dated 8 June 2015 in the maintenance book showed the family of one person had specifically requested that her name and photo be placed on her bedroom door. This was not shown as completed in the maintenance record and a physical check of the door on the day of the visit, showed there was no name or photo there.

Signs that were in place were misleading. For example, at inspection we noted two doors next to each other in a lounge area; both had the sign for toilet on the door. One however was a designated staff toilet and kept locked, this was misleading for people in the lounge seeking a toilet; the new manager agreed and took relevant action. The layout of the environment was difficult for staff to keep people within sight, and 'nursing stations' set within communal areas on both units provided an unnecessary institutional element to what is a residential care home, when sitting behind these counters, staff vision of what was

Requires improvement

Is the service effective?

happening in the communal space around them was severely limited. There was a lack of sensory equipment or adjustments made to suit those with sensory needs, and there was a risk they could become isolated and lose remaining independence.

There was a failure to ensure that the premises met the needs of people with dementia. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Procedures were in place to monitor people's health care needs. Care plans highlighted specific health care conditions that people had and how they were supported with these. A health contacts sheet recorded details of visits made by health professionals in response to requests from the service or as regular appointments, this included, dentists, chiropodist, optician, community nurse, GP, Psychiatrist dietician. People's weights were recorded monthly so prompt action could be taken to address significant weight fluctuations.

We spoke with two health professionals who visited the home on a regular basis. One was concerned that knowledge they had given to staff in relation to specific issues for people was not being widely shared within the staff team, or the learning used to inform support of other people with the same conditions. A relative told us that they were generally satisfied that their relative's health care needs were attended to.

Requires improvement

Is the service caring?

Our findings

We observed staff to be kind and patient when they were talking with people, but too busy to spend time with them. People were living with dementia and this affected their ability to comment about their experiences of care. However, we spoke to some of their relatives during and post inspection. All relatives were universally complimentary of the staff team who they described as being: "pleasant", "lovely"," kind", "helpful" and "caring", however two felt small improvements were needed in some areas, for example making sure staff were available to assist people with meals. Health and social care professionals spoke positively about the caring nature of the staff team, and one said they always found the service had a calm and relaxed atmosphere, and that staff showed a good understanding of people's needs.

Staff were discreet when carrying out personal care which was undertaken quietly, without fuss and doors were closed protecting people's privacy and dignity. However, we observed that away from personal care routines staff practices lacked understanding that maintaining a person's dignity was about more than, for example closing doors, or keeping their confidentiality. For example, at lunchtime, we observed staff sensitively handling the need for some people to wear food aprons to protect their clothes, but they were not routinely encouraged to wash/or cleanse their hands before or after they ate, although there was evidence that some people's hands were soiled and needed cleaning. We sat next to someone who had been assisted with their meal by a staff member. Although the support offered had been measured and at a pace to suit the person, with prompting and encouraging words from the staff member, the person was left with food on their hand which had not been wiped off, they were seen to be wiping this on themselves, brushing it into their hair and on the arm of the chair they were sitting in, and this compromised their dignity and the perception of them by others.

A relative told us some people were assessed by staff as being more independent and needing less support with their personal care, as in the case of the person they visited. From their own observations they considered this to be an over optimistic assessment and unrealistic for their relative. They said that whilst they were keen for their relative to retain as much independence as possible, they felt they were left to their own devices too much in regard to their personal care and clearly needed more supervision. For example on one occasion they were informed by staff their relative was in their room getting ready, when they went to the room they found their relative naked and confused as to what they should be doing. On a second occasion when they visited they noticed their relative was visibly flushed and uncomfortable. They saw that they were not only wearing their daytime clothes but had on their pyjamas underneath. Staff were not helping people to maintain their dignity.

We observed one person who was asleep on their bed and their bedroom door was propped open, and they were visible to other people in the lounge. We were informed that it was the person's wish to have their door open but when we checked their file, this had not been recorded in their care records, and there was no evidence to suggest this was a personal preference.

There was information on notice boards and on the menu board. This was not provided in formats that people could easily understand. Much of the information was in standard size written formats which did not meet the needs of many of the people there. No pictorial information was provided to visibly inform people about staff on duty, the activities of the day, their personal daily care activity plan, or the meals they could choose from. This compromised their dignity in being enabled to maintain a level of independence and make informed choices for themselves.

There was a failure to ensure that people's privacy and dignity was preserved and this is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On both days of our inspection we found there was a calm relaxed atmosphere and staff showed a caring and respectful attitude to people. People who were able to find their way to different parts of the service were gently directed away from bedroom areas if staff saw them. In most instances care staff although busy were observed to take time to acknowledge people by name when passing them and to exchange a few words or a brief chat.

People's bedrooms were in good order, contained all necessary equipment to meet their needs and those visited showed that people had been supported by relatives and staff to personalise their rooms with small possessions and photographs to help them settle in and feel more at home.

Requires improvement

Is the service caring?

Relatives said they were always made welcome by staff and never felt rushed or hurried when visiting, and felt able to visit flexibly without restrictions. They said that they felt they were usually kept informed about changes in their relative's health or support needs. One relative spoke positively about the fact that although some of their parents clothing had been ruined in the laundry, they had received an apology and been reimbursed by the service to replace these items and felt this showed that the service staff were listening and responding to them.

People were unable to express their own views about the quality of the service they received, but a forum for relatives had been established. This met regularly with the assistant manager to discuss matters relating to service improvements, developments, and planning of events.

Relatives said they thought the gardens had been laid out well and provided opportunities for people to sit quietly if they wanted. They spoke positively about "Gregory's Tea shop" this is a small wooden cabin in the grounds decorated to look like a small tea shop. Two relatives said this was a pleasant place for people to spend time, and they often went there when they visited their family member to drink tea, and also to eat their lunch.

Another relative said they supported the person they visited to maintain a small patio area with flowers as this was an activity the person enjoyed and they liked to spend time in this area. Other people were also encouraged to make use of this area and seating was available for them to do so.

Requires improvement

Is the service responsive?

Our findings

We observed that people were in positive moods, some were alert and actively walking around the premises, others were passive and sat for long periods in communal lounge areas with no interaction with staff or other people. People were living with dementia and not all could make use of group activities and needed individual attention. A small number of people attended an activity, but most were inactive and under stimulated. We spoke with some of the relatives, some of whom also attended relatives meetings. One relative said that they were disappointed that the motivational activities they were promised would be on offer to their relative when they came to live in the service had not materialised. They said they had queried this and been informed this was not possible due to lack of staff to support this.

A second relative said that they had noticed that people who were physically more able were provided with opportunities for a wider range of activities which included outings from the service. Several relatives commented about the gardens which they said were 'lovely but underused', because staff were not available to always support people there. Another relative said that they were surprised by our comment about activity staff because they had not been aware of them or noticed them when they visited, and had not been consulted about activities their relative might like.

A programme of activities was in place and this was facilitated by two staff that were identified as having carer/ activity roles. Several relatives mentioned observing music therapy sessions for people. One said they were impressed with the engagement they saw between people and the activity. We noted not all of the advertised activities took place on the 14 July 2015 the day of our inspection. Cake making had been listed as an afternoon activity, but this did not happen. There was sing-along session in the morning. This was termed 'music therapy.' Some people engaged in aromatherapy in the afternoon. A system had not been implemented to record which activities each person had attended, and how often they frequented these and what benefits they experienced from this. This kind of information would inform staff what the most popular activities were for some people, and identify those people at risk of becoming isolated by not engaging.

Advice from professionals about using activities to motivate and divert people was not being acted upon. For example in a care plan for someone whose behaviour could at times be challenging we noted advice given recently by a health professional. This stated: 'Staff might divert from being confrontational by offering various activities to raise her self-esteem and from which she will gain satisfaction'. There was no record in the person's care plan or elsewhere of what staff had done to provide activities to this person. A note in the person's daily record several weeks later recorded the person 'seemed quite bored this evening' but there was no record of any actions taken to alleviate this.

There was no evidence that activity time was set aside for those people who did not want to participate in planned activities, and who spent long periods on their own in communal areas or, in their bedrooms., No adjustments were made to the stimulation and activities available to people with sensory impairments, or in the activity staff were deployed to support those who did not benefit from group activities. We observed people who spent long periods of time in the same arm chairs without interacting with other people around them or staff. Some people were therefore at risk of becoming isolated within the service without opportunities for engagement with others.

The failure to provide a suitable range of activities that meet the needs of people living with dementia and or sensory impairments is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before people came to live at the service an assessment of their needs was undertaken to establish whether these could be met within the service. We were informed however, that two recent admissions had broken down because people had been admitted to the service whose needs could not be met, and their assessments had not been completed in depth with important questions about the level of support people needed around their behaviour not being asked. There was a failure to seek reports from other professionals to inform the decision to admit and that there were sufficient staff with the right skills to respond to the specific support people needed with their behaviour. As a consequence the people concerned had during the short time they were there, had an impact on the other people living in the service, because staff could not adequately support them.

Requires improvement

Is the service responsive?

People's care plans were individualised and contained details about each person's health, social and personal care needs, these should guide staff in the way people preferred and needed to be supported. However, changes to some people's care and treatment needs were not always updated in the records. There was a mis-match between what the records said and the actual delivery of support by staff. We observed several instances where staff support was appropriate and reflected current needs but records had not been updated to reflect this. Records were being reviewed but this was a cursory update and was not ensuring that important changes in support made aware to staff through handovers, and other forms of staff communication was similarly reflected in the persons care plan. There was a risk that new or agency staff reading the care plans could offer inappropriate support. For example, one care plan showed that the person's arm should be elevated due to fluid retention. Observation showed that this had not happened; the assistant manager confirmed that this information was out of date and should have been removed from the care file.

On a second care plan it was documented that the person had no mobility issues, but then later made reference to them walking with a frame and being at risk of falls. The assistant manager again said that there was some old information on the care file which needed to be removed.

A third care plan gave details about how the person was to be supported when out of bed. We learned the person now remained in bed all of the time, with half hourly checks. Given that this service relies presently on significant agency staff input, there is the potential that people will not receive the care they need because their care files which guide the support staff deliver have not been adequately reviewed and updated.

There was a failure to ensure detailed and accurate records were maintained of people's assessed care, treatment and support needs so staff were provided with current information and guidance, so that care could be provided appropriately and consistently. This is a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about people's former occupations, family connections and preferences had been sensitively recorded in their care plans, and their preferences around routines, likes, dislikes were also documented, this showed that time had been taken to gather this information from people or their relatives and relatives confirmed they were involved in reviews of care. People's wellbeing was discussed at staff handovers and staff meetings as appropriate. A monthly evaluation was undertaken, of each person's care plan, and internal reviews were held regularly.

A complaints procedure was displayed but not in a format suited to the needs of people in the service and this could prevent them from raising concerns. The assistant manager told us the complaints log contained three compliments and that no complaints had been received since December 2014. The incoming new manager showed us an emailed complaint dated April 2015 this had not been recorded in the complaints log or responded to. There was a risk that concerns and complaints received from people and relatives were not being acted upon.

Relatives gave mixed feedback regarding their own experiences of raising concerns or complaints. One said that although they found staff pleasant and approachable they did not feel satisfied that their concerns had been taken on board by staff. Two others felt that whilst they did feel their concerns had been listened to, they were never informed as to what action had been taken about the issues raised. A fourth said that a previous concern had been dealt with to their satisfaction, and they had no further cause to complain.

There was no system in place for the documenting of informal concerns other than in people's individual daily notes. Although the assistant manager said these would usually be dealt with quickly to people's satisfaction, the provider had no way of auditing the frequency or type of issues that arose, and whether staff practice was improved in learning from these events.

There was a failure to ensure that an effective complaints procedure was in place that assured complainants that their concerns were being acted upon, and that lessons learned were used to inform staff practice. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

Relatives spoke positively about the care staff and their attitudes towards the people they cared for. Relatives thought the interim management arrangements since the previous registered manager left had done well to keep the service running, but one relative commented they felt the management of service had become increasingly ineffective. Two other relatives felt there were aspects of service delivery that had not been managed well and were an indicator of a lack of management oversight.

The home had been without a registered manager Since October 2014. Since that time interim management plans had been implemented but had been ineffective. Action plans produced in response to a previous inspection in 2014 had not been fully implemented. Where improvements had been made these had not been sustained with shortfalls still evident in staffing levels, record keeping, safeguarding and incident reporting, all identified previously in the actions plans as areas for improvement.

People were at risk because staff lacked awareness of environmental health and safety issues, for example we found a missing door guard on a bedroom door and an exposed hot pipe that had not been reported by staff. Care plan risks were not being followed, and these areas had not been highlighted or monitored by the interim management.

People were at risk because systems to monitor service quality were not implemented effectively to ensure people were receiving a safe, quality of service At regular intervals the assistant manager and provider representatives undertook a range of audits such as ensuring staffing information, care plans, medicines; finance records were accurate and updated. Health and safety and the quality of cleaning and catering were checked; however, these audits were not completed robustly Actions for improvement were noted on some audits undertaken but none of the shortfalls identified from this inspection had already been highlighted by the internal service and provider audits undertaken. For example some people's health care records including nutritional information and fluid charts, or guidance about their health conditions such as diabetes were not always completed or accurate.

Shortfalls in staff training, competency and supervision frequencies had not been identified. Audits of the cleanliness of the premises and equipment were not robust. Systems to monitor resources were not being appropriately checked to ensure these were available. For example a relative expressed concern regarding a recent incident where the service had run out of continence pads. As a consequence people were left without pads and this compromised their dignity.

A record of incidents and accidents was maintained, these showed some incidents as a result of person to person interactions. Despite training given to staff, there remained evidence of some under reporting because there was a lack of consistency between incidents being recorded within people's individual behaviour monitoring records and also being recorded and counted as an incident in the service as a whole. Internal auditing procedures had failed to highlight this.

There was a failure to ensure that audits undertaken were sufficiently robust to highlight shortfalls in some areas of service delivery. For example, gaps in staff supervision and training, inadequate cleaning regimes, shortfalls in resources or accuracy of records. This is a breach of Regulation 17(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Policies and Procedures were in place and staff knew where to find them. However they were not embedded in everyday practice and the interim management of the service had not ensured that staff were familiar with these policies and were adhering to them. For example the frequency of staff supervisions, adherence to the palliative care policy, the management of complaints. These were routinely updated and adapted where necessary to meet the needs of the service, but there was a failure to ensure that staff understood and acted in accordance with the agreed policies and procedures of the organisation This is a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative's forum met regularly and we viewed minutes from this. Some relatives we spoke with were part of the forum, and felt this was a positive thing, but were concerned that they were not always made aware of the outcome of issues raised there.

Requires improvement

Is the service well-led?

Staff said they felt supported and were kept informed. Staff meetings were held regularly. Records of these meetings showed there was a good dissemination of information to staff about changes and new procedures, as well as issues arising within the service.

Discussion with staff and some relatives showed plans for the refurbishment of the premises. Plans for ongoing investment and development of the service had been shared with them. A management action plan had been developed to make much needed improvements to the service but these were still to be fully implemented.

Staff and the majority of relatives expressed confidence in the assistant manager who they said was approachable and felt that she had done well to keep things together since the previous manager retired. She was a visible presence in the home and was familiar to people in the service, and their relatives. Staff told us they could always go to the assistant manager or a team leader if they had something on their mind. A relative told us she had found no difficulty in approaching the assistant manager with an issue.

We observed good cheerful interactions between care staff at inspection. Care staff told us that they felt part of a team and that they all worked well together and felt well supported by the assistant manager and team leaders.

Feedback from social care and health colleagues was mixed with concern at the number of incidents occurring within the service recently. However, there was also recognition that the provider was striving to make the necessary improvements and adjustments to the service to ensure a safe delivery of care and support to people, after a period of decline.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care There was a failure to provide a suitable range of activities that met the needs of people living with dementia and or sensory impairments. Regulation 9 (1) (a-c) (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect There was a failure to ensure that people's privacy and dignity was preserved and this is a breach of Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was a failure to ensure that people's capacity to consent was assessed and their consent to care and treatment was supported appropriately within the everyday practice of staff. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a failure to ensure the safe administration of medicines was sustained. Regulation 12 (2) (g) There was a failure to ensure that risks were managed appropriately. Regulation 12(1) (2) (a) (b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The failure to ensure that staff had a clear understanding of their responsibilities to safeguard people from harm is a breach of Regulation 13 (1) (2) .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment There was a failure to ensure that bathroom and toilet areas were kept clean and that equipment was stored appropriately and maintained in a clean condition. Regulation 15 (1) (a-f) (2) There was a failure to ensure that the premises met the needs of people with Dementia. Regulation 15 (1) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints There was a failure to ensure an effective complaints procedure was in place which assured complainants that their concerns were being acted upon. Regulation 16 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a failure to ensure detailed and accurate records were maintained of people's assessed care,

This section is primarily information for the provider

Action we have told the provider to take

treatment and support needs so staff were provided with current information and guidance, so that care could be provided appropriately and consistently. Regulation 17 (2) (c)

There was a failure to ensure that audits undertaken were sufficiently robust to highlight shortfalls in some areas of service delivery. For example, gaps in staff supervision and training, inadequate cleaning regimes, shortfalls in resources or accuracy of records. Regulation 17(1) (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a failure to ensure sufficient, skilled staff were available to support people safely at all times to ensure they were provided with an appropriate level of assistance. Regulation 18 (1) There was a failure to ensure that staff had the right knowledge, skills and competencies to support people's care and treatment appropriately. Regulation 18 (1) (2) (a) There was a failure to ensure that staff understood and acted in accordance with the agreed policies and procedures of the organisation Regulation 18 (2) (a)

The enforcement action we took:
We have issued a Warning Notice.