Amore Elderly Care Limited

Charles Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 04 January 2017, with a further announced visit on the 10 January 2017.

Charles Court Care Home provides accommodation, nursing and personal care to a maximum of 76 people, divided over two floors. At the time of our inspection there were 62 people living at the home. At the time of our inspection there were 62 people living at the home. There were 29 people living on the nursing unit situated on the first floor and 33 people on the ground floor in the dementia unit.

There was a registered manager in post at the time of our inspection, who was due to shortly retire. A new manager had been appointed by the provider, who confirmed to us their intention to register with the Care Quality Commission (CQC). 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.

This service was last inspected in February 2016, when we did not identify any concerns with the care and treatment provided to people who used the service.

During this inspection we identified two breaches under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The provider had failed to deploy sufficient numbers of staff to meet people's care and treatment needs effectively. Staff repeatedly told us there were not enough staff to ensure people's needs were met, particularly at night times. The registered manager told us staff on the ground floor were deployed to ensure communal areas and corridors were always supervised. During our inspection we saw many occasions when people were left unsupervised in the main lounge. Corridors were often unsupervised. The provider told us that there had been a total of 21 reported falls during December 2016, of which 13 were unwitnessed falls on the ground floor.

The provider had failed to effectively assess, monitor and improve the quality and safety of services provided. We found leadership at the home lacked any clear strategy in relation to staffing levels and deployment of staff, with regard to ensuring people were safe particularly on the ground floor. Staff deployment was random and uncoordinated. People were left unsupervised and people at risk of falls were allowed to wander without any scrutiny. We found check/observation records were unreliable. Staff told us overall staffing numbers did not enable them to complete and record checks/observations accurately. Staff felt that management did not respond to their concerns and that there was a general disconnect between some staff and management.

Care provided was task driven with limited regard to the needs of people living with dementia. Staff

consistently told us they did not have time to sit and chat to people.

We have made a recommendation for the service to explore relevant guidance on the provision of good dementia care and practice within care homes.

Training and development for new staff was inconsistent. Whilst most staff told us they felt supported and received regular on- to-one supervision, some staff were adamant they had not received any.

People were not always provided with food and drink, which supported them to maintain a healthy diet. There were limited choices of meals available for people.

We saw little or no engagement / activities taking place with people who had remained in their bedrooms, though we saw an organised exercise events and singing taking place in the main lounge. Staff felt people did not receive enough stimulation at the home.

Staff knew what abuse was and how to respond if they suspected abuse. The provider had given staff guidance and training in protecting people from harm and abuse. We saw appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults.

People were supported to take their medicines as prescribed. Records supporting and evidencing the safe administration of medication were complete and accurate without any omissions. Staff that had received training in the safe management of medicines.

Registered nurses and the deputy manager were knowledgeable and clinically aware. Outside agencies were used to benefit and enhance their learning and development.

Staff understood the Deprivation of Liberty Safeguards and the provider followed legal requirements in relation to the MCA.

People were supported to access health professionals to make sure they received effective treatment to meet their specific needs. We saw that when required, referrals had been made to relevant health professionals and guidance followed

There was a system in place to capture and respond to complaints and feedback. People were provided with information on how to complain and would not hesitate to raise their concerns with staff or management.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had insufficient numbers of staff effectively deployed to ensure people received their care and treatment needs safely.

Overall, people were supported to take their medicines as prescribed.

Staff knew what abuse was and how to respond if they suspected abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Training and development for new staff was inconsistent.

People were not always provided with food and drink, which supported them to maintain a healthy diet.

Staff understood the Deprivation of Liberty Safeguards and the provider followed legal requirements in relation to the MCA.

Is the service caring?

Requires Improvement

The service was not always caring

Staff were very task focused with little regard to needs of people living with dementia.

People were treated with kindness and respect.

People felt involved in decisions about the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little or no stimulation / activities taking place with

people who had remained in their bedrooms,

People were stimulated in group activities.

There was a system in place to capture and respond to complaints and feedback.

Is the service well-led?

Requires Improvement

The service was not well led.

There was no effective leadership.

There were no governance systems in place to assess, monitor and improve the quality and safety of services provided.

Observation checks and records could not be relied upon as being accurate and reliable.

Charles Court 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 was an unannounced inspection carried out on the 04 January 2017, with a further announced visit on the 10 January 2017. The inspection was carried out by three inspectors and a specialist advisor in nursing. A specialist advisor is a person with a specialist knowledge regarding the needs of people in the type of home being inspected. Their role is to support the inspection. The specialist advisor was a nurse with experience in general nursing, residential care and dementia.

Before the inspection, we also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law. We also asked the local authority and Healthwatch for any information they had, which would aid our inspection. We received information highlighting concerns regarding the quality of care delivered at the home.

We spoke with 11 people who used the service and 13 visiting relatives and friends. We also spoke with three visiting health and social care professionals.

Additionally with spoke with four nurses and 14 members of support staff. We also spoke with the registered manager, the deputy manager (both manager and deputy manager were registered nurses), director of quality and compliance for the provider, two domestics, cook, receptionist, activities coordinator and the provider's dementia coach.

Throughout both days, we observed care and treatment in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at people's care records,

medication records and the quality assurance checks that had been undertaken by the provider.

Requires Improvement

Is the service safe?

Our findings

We found the provider had insufficient numbers of staff effectively deployed to ensure people were safe on the ground floor. One visiting relative told us about several incidents over the previous months where their relative, who was living with dementia, confronted people who had wandered into their room during the night. Their relative had reacted to the person entering their room and had sustained minor injuries. The relative told us, they firmly believed that had there been more staff on duty to support people with dementia, the disturbance and resulting injuries could have been avoided. One person told us, "I try to speak to staff outside my room. They (staff) say, I'll be back in a few minutes, but they don't come back." Another person said, "There's not enough staff, but it doesn't affect me a lot. They (staff) are pushed. They seem like they're rushed, they have too much to do." A third person said, "When I use the call-bell I often have to wait a long time. Yesterday, I had an accident, because they couldn't come soon enough. I know they are busy, but it boils down to there not being enough staff."

Staff repeatedly told us there were not enough staff to ensure people's needs were met, particularly at night times. One member of staff said, "Come midnight, there is not enough staff in my view. Not enough staff to meet people's needs in a timely manner. Most people require double ups (the support of two members of staff). People have to wait, which is not fair. I wouldn't have my family here, because it's too big." One nurse told us, "In my view there is not enough staff. This morning one person has had a fall, resulting in a cut to their head. They were taken to hospital. This person doesn't sleep and wanders. No one witnessed the fall, no staff were about. More staff would help supporting these people." Another nurse told us, "There is not enough care staff and we can't support people in the way they need. Care staff don't have time to sit and talk. We are running up and down corridors and don't have time to spend with people." Another member of staff said, "They need more staff on at nights. I don't believe two to three carers is enough." This member of staff described to us how a number of people wandered during the night and expressed concern about the lack of staff available to monitor corridors and lounges during this period.

One visiting health care professional told us they had mixed experiences with the home and felt there were not enough staff to support people at risk of falls. They believed the home environment was too big with too few staff. They told us that staff took too long to answer people's call bells and lots of people wandered into each other's rooms.

The registered manager told us staff on the ground floor were deployed to ensure communal areas and corridors were always supervised. During our inspection, we saw many occasions when people were left unsupervised in the main lounge. Corridors were often unsupervised by staff. One person, who we were aware had recently sustained a fall on the first day of our inspection, was seen to walk around the bottom corridor without any support or staff available. Another person was seen walking along the corridor in their night clothing. They entered a toilet and reappeared carrying their continence pad. No staff were in the corridor or immediately available to support them. They started to walk along the corridor with the pad. They were eventually supported by a passing member of cleaning staff, who removed the pad and assisted the person back to their bedroom. No care staff were available in the immediate vicinity to monitor and support these people, which contradicted what the registered manager had told us about corridors being

constantly monitored by staff. One member of staff told us staffing levels did not allow for the appropriate level of monitoring of people in corridors.

Prior to this inspection, we received information from the provider in the form of statutory notification, that three people had sustained serious injuries from falls during December 2016. During our inspection visit, the provider told us that there had been a total of 21 reported falls during the month of December 2016 alone, of which 13 were unwitnessed falls. Two of the serious injuries reported were also as a result of unwitnessed falls. One nurse we spoke with told us, that because of the low staffing levels there was a lack of staff monitoring in corridors. They made reference to people wandering into each other rooms and the lack of monitoring had potentially been a factor in people sustaining falls. Another nurse said "I think if we had more staff, including nights, that would help to reduce falls by providing more supervision of people."

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing. This was because the provider had failed to deploy sufficient numbers of staff to meet people's care and treatment needs effectively.

We looked at how the home managed risk with particular regard to falls management. The provider had assessed, recorded and kept under review the risks associated with people's individual care and support needs. They included information about what action was required to minimise the risks and included action in relation to falls, choking, skin integrity and safely administering medicines.

If people were involved in any accidents or incidents, staff understood the need to record and report these to senior staff or a member of the management team. Each person who lived at the home had their own personal emergency evacuation plan (PEEP) in place. These clearly explained how people could be safely evacuated from different areas of the home in the event of an emergency.

We checked to see how people who lived at the home were protected against abuse. Safeguarding procedures are designed to protect vulnerable adults from abuse and the risk of abuse. The provider had given staff guidance and training in protecting people from harm and abuse. Staff were able to tell us how to recognise when people were at risk of abuse. Staff were able to describe confidently what action they would take if they had any concerns and were aware of the service's whistleblowing procedures.

We found the home had appropriate recruitment procedures in place, which ensured staff were suitable to support people who used the service. We saw appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. We found appropriate Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained. DBS helps employers make safer recruitment decisions by preventing unsuitable people from working in care.

We found that overall, the management of medication at the home was safe. Medicines room were clean and well organised. Temperatures of medicine fridges were monitored daily and found to be within safe parameters. Controlled drugs were stored securely and safely in line with legislation. Records supporting and evidencing the safe administration of medication were complete and accurate without any omissions. Only staff that had received training in the safe management of medicines were able to administer medicine.

We observed how medicines were administered and found the right medicines were given at the right time to the right person. However, we observed one nurse who had left two tablets with a person, before ensuring they had been taken. We later spoke to the nurse who told us they would check with the person and sign the medication administration records (MAR) sheet at that point. We spoke with the nurse regarding the practice

of leaving medicines with a person and later returning to ask whether they had been taken and then signing MAR sheet. The nurse acknowledged that this did not reflect good practice together with accurate recording keeping.

Before our inspection, we received information of concern regarding the cleanliness of the home. We found the home environment to be clean without any unpleasant odours. There were a number of domestic staff on duty during our visits on both days and we saw them cleaning high risk areas such as handrails, light switches, door handles and doors as well as other routines. We looked at communal bathrooms and toilets and found these to be clean with supplies of hand soap in dispensers, paper towels and foot operated bins with lids. We did not see staff wearing jewellery (other than wedding bands), but were appropriately dressed wearing aprons and gloves when required. We checked people's bedrooms and en-suite facilities and these were also clean with supplies of hand soap and paper towels.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they believed staff were well trained and competent in their role. One person told us, "The staff here seem efficient." One visitor told us staff appeared to be well-trained and spoke positively about their knowledge of dementia in particular. They said "The level of understanding about dementia is entirely satisfactory." Another visitor told us they felt staff had the necessary skills and knowledge for the most part and said "I can ask them (staff) questions and they will answer me and give me a good explanation." One visiting health care professional told us there had been a desperate attempt to employ staff due to shortages and as a result staff hadn't received a proper period of induction.

The registered manager told us there was a core induction programme for care staff, which included a health and safety introduction. They described that all new employees attended an induction day, which included 'face to face' health and safety training and a four hour people handling course. New employees were given time off the floor and necessary support to complete their online training. Each member of staff was then assessed as to the amount of 'shadow shift' they required, which varied depending on previous experience. 'Shadow shifts' meant staff were paired up with an experienced member of staff until they were confident they were capable of working alone.

While some staff told us they were satisfied with their initial induction, others described only having had a limited induction and being "Thrown in the deep end." One member of staff told us they were just shown around and told to do some on-line training. Staff without a background in care described the induction process as poor and not preparing them for the role. Another member of staff said "I was shown around, that was about it. I did moving and handling training and then shadowing. I did on-line training in my own time. I don't think the induction I had prepared me for the role. Things weren't explained and I can't really remember it, so it can't be great."

Most staff told us further training / mandatory training was effectively organised and managed to meet the individual needs of staff. Staff confirmed they had received training in pressure sore management, Mental Capacity Act, emergency first aid and were annually assessed in moving and handling by an in-house trainer. One member of staff told us how they found the continence pad training particularly beneficial, as it showed them how to maximise the absorbency of pads and so keep people dry and comfortable longer.

We found that the registered nurses and the deputy manager that we spoke with were knowledgeable and clinically aware. They told us they were up to date with their practice and used outside agencies to benefit and enhance their learning and development.

During our visit, we spoke with the provider's 'dementia coach.' They described how they had been asked by the provider to support the home following recent concerns raised. They had provided training and guidance and observed staff practice when supporting with people with dementia. They explained they had no concerns with the majority of staff, though some individuals required additional support and supervision.

We looked at supervision and annual appraisal records and spoke to staff about the supervision they

received. Regular supervision and appraisal enables managers to assess the development needs of their staff and to address training and personal needs in a timely manner. We found one-to-one supervision of staff was inconsistent. Whilst most staff told us they felt supported and received regular on- to-one supervision, some staff were adamant they had not received any. One member of staff told us, "I have not had any one-to-one supervisions." Another member of staff told us they received regular supervisions with a nurse or the clinical lead, which took place every three to six months. They had also participated in a number of recent group supervisions. They told us they received feedback on their work performance and were able to raise issues or request additional training.

We looked at how people were supported to maintain good nutrition and hydration. We found people's dietary requirements were assessed and appropriate care plans and risk assessment were in place. Most people told us they were satisfied with the quality of food they received and had plenty to drink during the day. One person told us, "The food is pretty wholesome, I've got no complaints about the food." They confirmed they were able to choose what they wanted to eat for breakfast and the evening meal. Another person said that staff tended to put out their lunch, rather than offering them a choice. They said "I think they (staff) should put out different options, so you can choose." Other comments included, "Food is not bad, I eat all mine." "The food is not very good, we occasionally have a choice, but not often." "The food is average and we are given a choice. If we wanted something different I'm sure they would give it." "I get plenty to drink during the day."

One visitor told us the variety of food on offer was good. However, the meals tended to arrive quite cold when delivered to people's bedrooms. They also said lunch was served without offering a choice beforehand. Staff would only offer an alternative if their relative didn't eat what was placed in front of them. During the first day of our inspection, people were provided with a roast meal and vegetables. Staff told us no alternative was available unless people asked for something different. Staff also told us there was only one option available for people on soft and pureed diets. There was a lack of choice in respect of hot drinks as people were given tea to drink following their meal without other options. The meal was hot and appetising. Pureed meals were provided with no regard to presentation and looked uninviting. Staff told us that there had been talk of introducing small bowls for each item of purred food, so that it would look more appetising. They were still waiting for this to happen. Lunchtime was busy, but we saw people had appropriate levels of support and did not have to wait for their meals.

We looked at people's individual assessments. In one instance, we found staff were confused regarding their understanding of pureed meals and were not recording what people had eaten accurately. One person required pureed food and thickening fluids in their drinks as they were at risk of choking. When we looked at food charts for this person, staff were recording 'soft' instead of 'pureed' food. When we asked staff about this discrepancy, they told us "that's what we call it." We were also told that people on a pureed diet could have mashed potato. When we looked at the available mashed potato we saw it contained some potato skin, which was unsafe for a person on a pureed diet. This meant that people could be at risk of choking. We also found that this person, who was on a gluten free diet, was recorded as having being given sausage meat. We spoke to the chef who confirmed that the person was not allowed to eat sausage meat and was in fact given pureed bacon. They said that care staff should have known this person must not eat sausages and believed staff had wrongly assumed it was sausage meat as opposed to bacon. We spoke to the deputy manager about these recording issues.

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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with were able to describe the principles of the MCA legislation as supporting people to make choices. They were able to confirm they had received training. We found DoLS applications had been made on a case-by-case basis, following an appropriate assessment of each individual's capacity and care arrangements. We found where conditions had been stipulated on people's current DoLS authorisations, these were being met by the provider. During the inspection, we saw evidence of mental capacity assessments and best interest decision-making on people's care files in relation to flu jabs, taking of photographs and DoLS applications. Throughout the inspection we saw staff seeking consent and approval before undertaking any task with people, such as providing support with personal care or mobilising. Staff were polite and professional.

People told us that they were supported to access health professionals to make sure they received effective treatment to meet their specific needs. We saw that when required, referrals had been made to relevant health professionals and guidance followed. These included Tissue Viability Nurse, Dietician, Chiropodist and specialist nurses such as Parkinson's Disease and Diabetes.

Requires Improvement

Is the service caring?

Our findings

Prior to the inspection, we received concerns regarding the quality of care provided at the home. Care provided was task driven with a limited regard to the needs of people living with dementia. Throughout our inspection, we saw staff were busy undertaking tasks supporting people's needs, such as personal care. We saw very little engagement with people outside these specific tasks. Staff consistently told us they did not have time to sit and chat to people, which we observed. This was particularly apparent on the ground floor. People who remained in their bedroom during the day had limited engagement with staff. Though checks were undertaken by staff, this did not necessarily involve any meaningfull interaction between staff and people. One member of care staff told us, "The role is very task driven and we have little time to spend with people, which is worse when (staff) sickness plays apart."

During the inspection, we noticed one person who had been asleep in a chair in their bedroom throughout the morning. Though staff were seen to pass the room, we did not see any staff member entering the room and engaging with the person. Staff told us people were regularly checked, which was then recorded on a check/observation chart. We looked at the check/observation chart for the person we had observed sleeping in their chair. It recorded the person had been checked every hour. This was not consistent with our observations as we had not seen staff entering the room and engaging with the person throughout the morning.

On the second day of our visit after lunch, we observed people being taken into the main lounge, either in their wheel chairs or being supported as they walked. People were then encouraged to sit down or were hoisted into chairs. Everyone was positioned facing the main television. No one was asked by staff whether they wanted to watch TV or were offered an alternative channel. At the same time, a radio was playing loudly at the back of the room, which was eventually turned off by a member of staff. We found the approach of staff very task specific with little regard shown as to what people wanted to do. When staff were sat in the main lounge, they were occupied completing checks/observation charts for people or updating care plans. On one occasion, we saw a cleaner hovering the main lounge when the TV was on and a number of people were present. They had no regard to the disturbance this may have caused.

We recommend the service explores the relevant guidance on the provision of good dementia care and practice within care homes.

One member of staff who had been supporting a person on end of life care told us "I do sit with (person's name) occasionally, but we are very busy and don't have time to sit with people." One nurse told us, that with people on end of life care, though they undertook regular checks, they did not have time to just to be with people, who had no family, as they approached their death.

We looked at diet notification sheets for people, which contained details of what people liked and disliked. Records for one person we looked stated the person 'dislikes soup.' Yet on reviewing what people had eaten and drunk, this person had been given soup on several days prior to our inspection visit. We spoke to the deputy manager about these concerns, who assured us immediate action would be taken to address this

matter with staff.

Most people told us they were treated with kindness and compassion by staff who adopted a very caring approach. One person told us, "They (staff) do seem to care about people." Another person said "I get good care, they look after me well here." One visitor told us, "The physical environment is safe and it's the attitude of all the staff. It's more than just doing the job for them." Another visitor said they felt staff were very caring even to visitors and would often bring them a hot drink."

Other comments from people included, "I can't say anything other than staff are very helpful and caring." "My relative is always clean, tidy and comfortable. The staff are friendly and pleasant. I have never had any concerns since my relative has been here." "The staff are very kind and caring." "We are very happy. Our relative looks better since coming here. The staff and nurses are very good." "No concerns about the care my relative is receiving, couldn't be in a better place." "The staff are sensitive and compassionate." "The care has been genuinely caring and sensitive. I can't emphasise enough how much I observe staff and have never seen any issues."

During our inspection, we saw instances of caring and respectful interactions between staff and the people living at the home. This included when supporting people to mobilise or eating. Staff took time to explain to people what they wanted to do such as when hoisting or supporting people to use the toilet.

People told us staff always respected their dignity and privacy. One person told us, "They are very respectful of my privacy and always treat me with respect." One visitor said "Staff are very respectful and mindful of my relative's privacy. They always make me feel welcome and really try hard." Another visitor told us, "I have never seen anything other than staff being respectful." Other comments included, "They respect [person's name] privacy over personal matters. They also respect their right to choose what she wants to wear. They understand that she wants to look decent." Staff told us how they recognised the importance of treating people with dignity and respect. They provided examples of knocking on bedroom doors before entering people's room. Greeting people on entering their rooms, turning on night light first in morning so that they didn't startle them and taking the time to ask what they preferred to be called.

People and their relatives told us they felt actively involved in decisions about the care and support they received. They told us nursing staff kept them fully informed of any health issues and action taken. One relative told us that they felt very involved in decisions regarding their relative's care and support. They attended periodic care reviews with the lead nurse. They said "She will sit down quietly with us and go through everything." Another relative said "I'm very involved and consulted regularly about the care my relative receives."

We asked staff how they promoted people's independence and choice. Staff told us they understood the importance of supporting people to make decision around day-to-day issues, such what they wanted to wear or eat. One member of staff said "I encourage people to be as independent as possible when washing and dressing." Another member of staff said "With independence, I try to encourage people to be independent where possible, such as eating themselves and assist them with things they can't do."

Requires Improvement

Is the service responsive?

Our findings

People told us they felt the provider was responsive to their or their family member's needs. One relative told us they had previously raised an issue regarding staff's understanding off adding 'thickener' to their relative's drinks. The felt the provider had immediately addressed their concerns. They also said, "They're all very open in their responses." Another relative said, "Where I have raised concerns, the nurses and staff always listen and take action. I have confidence in what they do." Other comments included, "Always quick to respond to any issues. Little things like providing a vase for flowers. Nothing is a problem." "Really good at responding to any issues we have. All the carers are good."

We looked at how the home provided stimulation and activities for people. The provider employed a full time activity coordinator, who was supported by other members of staff. Most people commented positively about the activities on offer. People told us they enjoyed singing hymns with visitors from the local Baptist church each Wednesdays. One person said, "There is more than enough for me to occupy myself with." One person told us that the activities coordinator worked hard at arranging things for them to do, which included trips out and various arts and crafts in the lounge, but there was only so much one person could do. One person told us they were unhappy with lack of opportunities given to access the community and had only been out three times since moving into the home in August 2016. One relative told us, "They have tried activities with my relative, but they prefer being on their own. The activities lady does spend time with our relative though." One member of staff told us, "I think if residents were more occupied, it would distract them from wandering around and falling may be." Another member of staff said, "Not enough stimulation for people who are in bed and we don't have time to sit and chat as we have jobs to do." A third member of staff said, ""There is definitely not enough activities for people, its to much work for the activities coordinator and staff don't have time."

The activities coordinator told us that more stimulation and organised activities were arranged for people on the ground floor. People were also taken out on trips and for drives with the home's own mini bus and that they linked in with the Herefordshire Art Centre. Where people declined to engage in organised activities, the coordinator told us they scheduled one to one engagement in their own rooms. During our inspection visit, we saw little or no engagement / activities taking place with people who had remained in their bedrooms, though we saw an organised exercise events and singing taking place in the main lounge.

People told us their needs were assessed before they moved in to the home. We saw that people's care plans contained details of their life history, preferences and individual care needs. People's care and treatment was provided by a staff who were able to describe in detail each person's needs and abilities. This was reflected in the care plans we looked at. Each person had care plans in place, which provided guidance for staff about how best to meet each person's needs. This included information on people's medication, personal care needs, and mobility requirements. People told us they were involved when reviews of care were undertaken by the provider.

We found the service had systems in place to routinely listen to people's experience, concerns and complaints. People told us that they had been provided with information on how to complain and would

not hesitate concerns with staff or management. The service had a complaints policy and procedure in place. This provided information about how people could inform staff if they were unhappy about any aspects of the service they received.

Requires Improvement

Is the service well-led?

Our findings

We asked people about management at the home. Most people we spoke told us that they rarely saw the registered manager within the home. One person told us, "I know the deputy manager, but I don't know the manager other than at resident meetings. They never come and talk to you." One person told us, "It's better than it was, they are trying really hard. The care is inconsistent, some staff are good, others not so good. Staffing levels are inconsistent with staff on some days responding to bells quickly, other days it goes on for ages."

We found leadership at the home lacked any clear strategy in relation to staffing levels and deployment of staff, with regard to ensuring people were safe particularly on the ground floor where people were living with dementia. This directly related to the high number and seriousness of falls sustained on the unit. We had no clear sense of who was in charge of staff on the unit. Staff deployment was random and uncoordinated. People were left unsupervised and people at risk of falls were allowed to wander without any scrutiny.

People who presented a risk to themselves were not always effectively supported by staff. With regard to falls management, the provider emphasised a focus within care plans and risk assessments about the importance of undertaking regular checks on people. This was part of their management strategy to minimise falls and keep people safe. However, staff were not individually deployed to monitor individuals at risk and observation checks could not be relied upon as being accurate and reliable. Staff repeatedly told us that current staffing levels did not allow for the appropriate level of monitoring of people and as a result checks/observation record were unreliable. They also told us that 'checks' were not allocated to specific members of staff to assume responsibility for. We also observed these records were not completed contemporaneously by staff. Additionally, the check/observation record simply recorded an hourly check for example, but did record the details of the member of staff person who had undertaken the check. This meant the records could not be checked by the provider for accuracy.

A number of staff told us that concerns about staffing levels had been reported to management, but without any resulting action. A number of staff felt that management did not respond to their concerns and that there was a general disconnect between some staff and management. One member of staff told us, "The manager takes little interest and doesn't really know what is going on with individuals. We (staff) don't see them much at all." Another member of staff said "I raise issues with the registered manager, but nothing changes. They are not interested." Another member of staff told us they were frustrated with the lack of interest shown by the manager. They had raised concerns on behalf of staff with the manager, but had ended up just "sorting it their self." Other comments included, "The deputy manager is always on the floor, but I rarely see the manager on the floor, which is the only way you get to know what's happening."

Another member of nursing staff told us that on ground floor where people with dementia were living, it was too big and the mix of residents was wrong. They felt there was a lack of clear thought around the mix, location and diagnoses of people throughout the ground floor. We were told that these and other concerns had been raised with the registered manager, but nothing had changed. They provided an example where a suggestion had been made to the registered manager to open the other dining room on the floor. This was

due to current noise levels experienced within the one dining room as a result of the numbers of people using it. They were told by the registered manager, there was insufficient staffing to facilitate this and the suggestion had simply been dismissed.

One visiting health care professional told us the manager had little knowledge of people's needs. They had no confidence in their knowledge and would always consult with the nurses instead. Another health care professional told us that the manager didn't know residents or staff. They did not believe the manager was able to support staff in how to meet people's needs and how to deal with their relatives. However, they believed the deputy manager was a positive development for the home.

Though we found a range of checks were undertaken by the provider to monitor service provision, these were not always effective as demonstrated by the concerns we identified. These related specifically, to staffing levels and deployment, falls management, accurate and reliable record keeping and choices at meal times. We were not assured that adequate governance and quality assurance systems were in place to ensure the provider was able to identify, address and monitor any concerns or risks relating to care.

This a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). This was because the provider had failed to effectively assess, monitor and improve the quality and safety of services provided.

Providers are required by law to make statutory notification to CQC and included serious injuries and granted DoLS authorisation. During our inspection the registered manager acknowledged that they had not kept up to date with statutory nonfictions regarding granted DoLS authorisations, due to an oversight. They told us they would ensure such notification would be submitted immediately. This matter will be dealt with outside the inspection process.

During our inspection, we spoke to the operations director for the provider. They told us that the current registered manager was due to retire and that a new manager had been appointed, who we met on the second day of our inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to effectively assess, monitor and improve the quality and safety of services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to meet people's care and treatment needs effectively.