Healthcare Homes Group Limited

Fornham House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 December 2015 and was unannounced.

The service provides accommodation for up to 73 older people some of whom may be living with dementia. At the time of our inspection 61 people were living at the service. We last inspected the service on 31 March and 14 April 2015 and found there was a breach of regulation 9 of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) which relates to person centred care.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service and their relatives commended the professional and caring nature of the staff. However this was compromised by the lack of adequate staffing which nearly everyone we spoke with commented on. There were not always enough staff on duty and people were not confident their needs would be met promptly. The geography of the building was a further consideration as staff were not a visible presence.

Staff were trained in keeping people safe from abuse and understood their responsibilities should they suspect abuse had occurred. Staff were able to outline how they would report any concerns they had.

Risks to people's health and wellbeing were assessed and reduced in most cases but risk assessments were not always promptly updated following a change in need. Medicines were mostly well managed but some errors were identified.

Staff received a structured induction and training was provided to equip them to carry out their roles. Some staff had not received all the training they felt they needed. Experienced staff demonstrated a good knowledge of the people they were supporting and caring for and knew people's particular preferences and wishes with regard to their care. Some newer staff and agency staff did not know people's needs well which meant we were not assured they could meet their needs effectively.

We saw that most staff had not received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. Staff lacked an understanding of MCA and particularly of DoLS.

People who used the service were very positive about the food and were able to exercise choice about their

meals. Meals had improved greatly in recent weeks. Mealtimes were seen to be very sociable occasions which people greatly enjoyed. People identified as being at risk of not eating enough were referred to appropriate healthcare professionals and monitored. However records relating to people's eating and drinking did not clearly show that people were always drinking enough for their needs or how this was effectively managed.

People were supported to access healthcare professionals when they needed them and the staff involved relevant professionals when a person's health declined.

Staff were caring and committed and we saw that people were mostly treated respectfully and their dignity was maintained. We did observe some poor practice with regard to respectful language and maintaining dignity. The atmosphere was of a friendly and happy place and the good relationships between staff, the people they were supporting and visiting relatives were observed throughout the service.

People were involved in assessing and planning their care. People's care was regularly reviewed but care plans were not always updated to reflect their most current needs. This was a concern due to the number of new and agency staff who were not familiar with people's individual needs.

People were supported to follow different interests and hobbies and had some involvement with the local community. People living with dementia and those who did not wish to take part in structured activities were not always meaningfully occupied.

Formal complaints were logged and investigated in line with the provider's complaints procedure. Concerns raised informally, via meetings for example, were responded to, sometimes formally, and resolved to people's satisfaction.

Staff understood their roles and but were not always well supported by the management team. The shortage of staff over the last few months had had a significant impact on the staff. The culture within the staff team was poor and the staff team did not work well together. The registered manager and new regional manager were clear about the priorities for the service and had already started to make the improvements that are required.

There were several breaches of regulation identified during this inspection and we have made one recommendation. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet the needs of the people who used the service.

Medicines were not always managed safely.

Risks were assessed and measures taken to reduce them but they were not always appropriately updated following a change of need

Procedures were in place to protect people from abuse and staff had been trained to recognise the signs of abuse and knew what action to take in response to concerns.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive all the training and support they needed to carry out their roles.

Staff and management were not clear about the requirements of the MCA and DoLS.

People were not always well supported with their eating and drinking.

People had good access to healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring.

The majority of staff were very caring, kind and compassionate. A small number of staff did not use respectful language and people's dignity was not always maintained.

People were encouraged to express their views and were consulted on aspects of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in assessing and planning their own care.

People were able to follow their own interests and hobbies. There was a lack of one to one time and meaningful occupation for people living with dementia or those who chose to remain in their rooms.

The service was not proactive in asking for feedback but responded to any informal concerns raised promptly and to people's satisfaction.

Formal complaints were managed appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, and their relatives, were involved in developing the service.

Staff understood their roles and but were not well supported by the management team. Staff morale was low.

The new management team worked well together and had a clear idea of the required actions needed to improve the service and had begun to put these in place.

Fornham House Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 21 December 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for someone who used this type of service.

Before we carried out our inspection we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law. We also looked at previous inspection reports.

We spoke with twenty one people who used the service, ten relatives, sixteen care staff including senior staff and activity staff, the chef, two members of the domestic staff, the registered manager, quality assurance lead and the regional manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us easily or chose not to. We also spoke with one healthcare professional and the local authority safeguarding team to gain feedback about the service.

We reviewed ten care plans, four medication records, two staff recruitment files, staffing rotas for the weeks leading up to the inspection and records relating to quality assurance.

Inadequate

Is the service safe?

Our findings

People who used the service, their relatives and staff told us that they did not feel the staffing levels were sufficient to meet people's needs and this was also our observation. One person who used the service told us, "There can be a shortage of staff at weekends. Agency staff are always used but don't seem to know what to do". Another commented, "There are not enough staff. It takes ages for them to come". Three staff told us they would not be happy to place a relative of theirs at the service due to concerns about staffing. One staff member said, "I would not bring my family here. We are all too rushed. We don't have enough time with them".

A relative told us, "Sometimes [my relative] is not up until 11.50". Several other people also told us this and it was backed up by several staff members. One member of staff explained, "We are still washing people and don't normally finish until 1pm. Listen to the buzzers. We have no one to answer them". Call bells were heard throughout the day and staff did not appear to answer them promptly in all cases. One relative said, "My only concern is when they press the buzzer for the toilet – they are not quick enough. When we are sat in the lounge…. I usually have to go and find them as you can't see them about". Another relative, who was visiting on the day of our inspection, made the same point saying, "[My relative] rang the bell for the toilet at 14.15 and it was 20 minutes before the girl came and had to go and get a second one but they were back within 5 minutes".

Records of recent call bell response times revealed that sometimes people had to wait considerable amounts of time for a response. We look at records two days in the week leading up to the inspection and found that that waits of more than ten minutes were common and people were recorded as having to wait up to 25 minutes for their call bell to be answered. We spoke with the regional manager and the registered manager about this and they told us that the service had recently recognised that waits were excessive and had ensured the system diverted to an emergency alarm after 10 minutes. Although it was encouraging that the service had begun to address this issue we saw that there were still problems and the impact on people of continually ringing bells was significant and negative.

Several people commented on the constant ring of the call bell and one person had asked for the bell to be moved from outside their bedroom. This had been done but this had merely relocated the problem without resolving the underlying issues effectively. Another person who used the service said, "People should not have to put up with the loud call system all the time". One member of staff said, "Buzzers – when you are working [supporting people in twos] you cannot leave people when you are caring and we cannot answer the buzzers quick enough". Another staff member commented, "They have not got enough people to check on people in their rooms and they only see them if they have buzzed".

We reviewed staffing rotas for the weeks leading up to the inspection and noted that sometimes staffing levels fell below the numbers the service had assessed as safe. Prior to the inspection we had been made aware of occasions when the service was running with very low staffing. We found that levels had improved since that time and a new dependency tool was being trialled, but were concerned that at times staff did not appear to be able to provide prompt care. For example we saw that the night shift began at 8pm and staffing

numbers reduced to five. On one occasion we saw that numbers had reduced to four as a member of staff was off sick. People required care and support throughout the day and night, some requiring two staff to help them. We were not assured that this level of staffing was appropriate for the number of people who used the service, which we were informed, had been 57 at that particular time.

The nature of the large and spread out building presented an additional staffing challenge and we found that the poor deployment of staff meant that sometimes people had to wait too long for attention. The main office for care staff was on the ground floor and staff congregated in there to access records. This meant that, at times, the service had no visible staff presence. One person remarked, "You don't always get quick attention. At night there is not always someone about… It is quite a big building and you feel all alone and cut off… I could not attract anyone and I felt alone in the world". The manager and regional manager had already identified that they needed a second base for staff but had, as yet, not found a suitable location for this. They were also trying to look at different ways of deploying staff to improve the current situation.

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

There were arrangements in place for the safe administration of medicines, including controlled drugs. The majority of people told us they received their medicines on time although one person told us they sometimes had to wait for pain relieving medicines. They said, "It should be 8.30 to 9.00 but sometimes, when they are busy, it could be 10am and ….it should be on time". Another person told us that there had been problems when their relative had first moved in. They said, "We had one or two hiccups with meds at the start when they ran out of meds and as a new patient here it was a problem getting them from Boots and they got them a day later".

We observed a member of staff administering medicines to people and saw that they did not rush and took time to speak to each person and ensure they understood what their medicine was for and establish if they were happy to take it. Each person had a medication profile which included a recent photograph and documented any allergies. Protocols were in place to guide staff when giving prescribed PRN medicines which are given as and when required and not consistently.

One senior member of staff took overall responsibility for all matters related to medicines and we found systems were in place to organise and manage medicines. We observed a person who administered their own medicines discussing their medicines with this member of staff and they told us, "[Staff member] is really on the ball". Procedures were in place for the safe booking in, storage, administration, stock control and disposal of medicines. We viewed records of the administration of medicines and found them to be mostly accurate and complete. We did find some gaps on the MAR sheet where staff had failed to sign to confirm they had administered a medicine and one person had a missing tablet in their blister pack which staff could not explain. Stocks of six medicines, including controlled drugs, were checked and found to be accurately recorded.

Staff had received the appropriate training before they administered medicines and medicines audits took place regularly. Some of these audits could not be located so it was not possible for us to be sure that required actions had always been followed up. We did see that audits had identified a number of errors such as a person's pain relieving morphine patch being administered after it had been discontinued. Where errors had occurred, this had been addressed with the individual staff members concerned. We were notified of three further errors straight after our inspection visit. These concerned giving additional medicines to one person, not giving another person their diabetes medicine on eight occasions and confusion about the application of a person's morphine patch.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12. (Regulation 12 – 1, 2 g)

We saw that risks were assessed and regularly reviewed. However we did not always find that risk assessments had been updated when people's needs changed. For example we case tracked one person who had recently been discharged from hospital. They had had an assessment when they came back to the service but their care plan had not been updated. They now had some medicines in liquid form as they had difficulty swallowing but their risk of choking on food and inhaling it into their lungs had not been reassessed. This placed them at risk of harm.

A second person had been assessed as being unable to use their call bell and at risk of falling out of bed (they had done this previously on several occasions). The risk assessment documented the measures that were needed to keep this person safe, such as a crash mat by their bed and regular checks at night. We found that there was no crash mat in place and it was unclear how often staff had been checking the person. We established that the person was now immobile and nursed in bed but it was not clear that all measures had been put in place prior to this to ensure that they remained safe. We were not assured that this person's risk of falls had been well managed.

We were concerned that effective systems were not always in place to reduce the risk of people developing pressure ulcers. For example we saw that some people had repositioning charts in place but some charts had not been consistently filled in, some were not clear about how often a person needed to be repositioned and some contained conflicting information. In addition to this we found that several pressure relieving mattresses were bleeping. One stated that the pressure was too low. When we asked staff about this they were unable to tell us what the problem was and turned the mattress controls off and on again to stop the noise rather than thoroughly investigate the issue. This meant we could not be assured that people were receiving the correct care to prevent them developing pressure ulcers.

We found that the particular risks related to the geography of the building had not been effectively assessed with regard to how staff were deployed. We found that on the top floor there was a period of half an hour where no staff were present. Some people on this floor were not able to use their call bell and were not independently mobile.

This was a further breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 12. (Regulation 12-1, 2 a, b).

People told us they felt safe living at the service and were at ease in the company of the staff. One person told us, "I feel safe here; I'm not worried about anything". A relative commented, "I do feel [my relative] is safe here". We found that systems were in place to reduce the risk of abuse and to ensure that staff knew how to spot the any signs and symptoms of abuse and take appropriate action. Staff were able to tell us what they would do if they suspected or witnessed abuse and knew how to report issues within the company but were not clear about raising issues with external agencies such as the local authority.

Most staff had received training in safeguarding people from abuse. The provider took appropriate action if they suspected abuse might have taken place and the manager was clear about their responsibilities related to keeping people safe.

Staff employed at the service had been through a thorough recruitment process before they started work. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal

record which would exclude them from working in this setting. References and DBS checks were confirmed before staff started work at the service. Agency staff were occasionally used to cover shifts. The provider checked that they had received the appropriate training and had the correct DBS checks in place before they started work.

Requires Improvement

Is the service effective?

Our findings

Everyone was very positive about the food and people enjoyed their lunch in a relaxed and sociable atmosphere. One person summed this up saying, "Food is varied, it is good quality and nicely presented. There is bags to eat and if you don't like the food they will find something you do like". Improvements had been made to the menu and these were appreciated by people who used the service. One person said, "The food is always hot – it has improved so much". 20 people chose to eat lunch in the dining room on the day of our inspection, with others choosing to eat in their rooms. Lunch in the dining room was a pleasant, sociable and well organised occasion. Drinks were regularly topped up and people were encouraged to be as independent as possible.

We were concerned that those people who had been assessed as being at risk of not eating and drinking enough were not always being closely monitored. There were 13 people identified as being at risk and although some people were well managed and had attained a healthy weight, the records for others showed that this was not the case for everyone. Records sometimes conflicted which meant we could not get a clear picture of how concerns about eating and drinking were being managed. For example one person's daily records stated that they had eaten and drank well but their food and fluid chart stated that they had not. This conflicting recording placed them at potential risk.

The chef had a list of people's particular dietary needs and prepared homemade, high calorie shakes and fortified foods for those at risk of not eating enough. We saw that one person had been promptly referred to the dietician and a care plan put in place to maximise their nutrition. Their weight had steadily increased and they were no longer seen as being at risk. They told us, "I was on a list but I've passed!" We also saw examples of where the service was not supporting people so well. This was particularly the case with fluids.

We case tracked five people who had not been identified as being at a particular risk of low fluid intake. We found that all of them had received a total of less than their target fluid intake of 1500ml over three consecutive days. One was recorded as receiving only 230 mls on one day. One person's daily notes made no reference to their low intake so we could not be certain that all staff were aware of it. Two of these people had subsequently been referred to the GP. Two other people had recently been discharged from hospital and were recorded as having concerns related to their kidney function and being prone to urinary tract infections. The continued low fluid intake placed them at further risk.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 14 - 1.

The care staff demonstrated an awareness of the MCA 2005 and the Deprivation of Liberty Safeguards (DoLS), but understanding was not good and most had received no training. There was confusion at all staff levels regarding DoLS and MCA. Staff were able to support people to make day to day decisions, such as what to wear or eat. One staff member said, "MCA is important because it promotes individuality". We saw that one person had had a Best Interests meeting regarding accessing the local community. However we also saw that another person had been assessed as having capacity to make their own decisions but their

relative had signed to state that they could not give their consent. Records were conflicted about whether they did or did not have dementia and we saw that they had received an influenza vaccination and no consent for this had been recorded. Conflicting information in records and staff's lack of understanding meant that we could not be assured that the correct procedures were in place to ensure valid consent was given for people's care and treatment.

DoLS applications had been made for two people to have bedrails fitted. However both people had been assessed as having capacity to consent to this themselves which meant that an application to the local authority was not necessary. Some staff were clearly confused about MCA and DoLS. One staff member told us, "There are a few who don't have capacity I think. We are not told. I don't know if DoLS applications have been made".

We recommend that the service provides suitable training and learning opportunities for staff, based on current best practice, in relation to the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Most staff knew the people who used the service well and were able to tell us about people's day to day care needs. We were concerned when three members of staff told us that they felt did not always have time to read care plans and relied on verbal handovers to understand people's current needs. One staff member said, "I don't read care plans; there is not time". During our inspection two staff on the top floor, one agency and one permanent, were not able to tell us how many people lived on that floor or what their needs were. They were observed spending time waiting for a more experienced member of staff to assist them.

Two staff commented that they did not feel they had enough training to support people effectively. One said, "I don't feel that I have the training required as the people are high dependency". Another commented that they had been asking for particular training since August 2015 but this had still not been provided for them. Conversely some staff, including senior staff, felt they had received adequate training and felt well supported in their roles.

Overall people who used the service and their relatives felt that, although they had concerns about the availability of staff, they were happy with the way the staff provided care and support. One person said, "I could not fault the care. They ask how they can help and if they are busy they say 'we will come back when we have finished whatever [we] are doing'". A relative remarked, "It is very good and I cannot complain. The service is good… and [my relative] is looked after very well". One relative expressed a concern over the lack of understanding of dementia some staff demonstrated, saying, "Staff struggle to understand dementia".

We viewed the induction and training records for staff. We saw that new staff were given a structured induction which included shadow shifts where they worked with an experienced member of staff. Staff received the training they needed during their induction and had meetings with the manager to discuss their progress. Staff training records showed that established staff received training such as moving and handling, infection control, fire, first aid and dementia awareness. Records supplied were not always current which made it difficult to establish how many staff had received training in some cases. Some staff had gaps in their training record, notably in first aid, food hygiene and dementia awareness which meant we could not be certain that all staff had received the training they needed to carry out their roles effectively. No staff had a record of training related to end of life care or the Mental Capacity Act (MCA) 2005 and issues of consent.

There was a mixed picture regarding supervision and an annual appraisal for staff. Records were not clear about the frequency staff had received supervision and there was no overall matrix. Staff told us that supervision sessions were rare and one person said they had only had one supervision session in twelve

months. Most staff said they did not feel well supported and did not always find the supervisions sessions helpful, when they had them. A senior member of staff told us that they did feel supported and managed to meet with the manager each week to catch up.

Records showed that people had access to a variety of healthcare services including GPs, district nurses, opticians and occupational therapists. We saw that the mental health and falls prevention teams had been appropriately involved in people's care. We saw that one person who had diabetes had had their condition reviewed recently and staff were supported by the district nurses to monitor the person's health.

Requires Improvement

Is the service caring?

Our findings

People and their relatives commented very positively about how kind and caring the staff were. They told us they were kind, respectful and well trained. One person who used the service told us, "This is the best place to live. The staff are unbelievably kind". A relative commented, "They are always short staffed but they are warm, caring and loving staff but they need more of them". Another relative said, "The staff are lovely. They always telephone me. Last week [my relative] had a hospital appointment and they took them] and stayed and chaperoned [them]".

We witnessed some very caring interactions between staff and the people they were supporting and it was clear that relationships were easy and friendships had developed. We witnessed a member of staff supporting a person to eat their meal. They showed kindness and encouraged the person to eat and do as much for themselves as they could. Their language was supportive and friendly and the person responded well. We spoke to another person who needed a lot of support with all their care needs. They told us, "They let you be as independent as you want to be".

People told us that staff responded kindly if they were distressed or in pain. We observed a carer supporting a person to use their walking frame. They showed compassion and concern when the person became short of breath and sat with the person until they felt well enough to continue. One resident told us, "They are very caring and helpful…. I came from hospital and they have looked after me very well".

People were involved in making decisions about their care. There was evidence that most plans were reviewed with the people they concerned or their relatives if appropriate. People told us they were given the opportunity to give their views about the care they received. One person was able to tell us in detail about how they ensured staff provided the care they needed in a way they were happy with. They told us, "I am more than happy with how they look after me". Resident and relatives meetings were held and people told us these gave them the opportunity to ask questions and share ideas.

People were mostly treated with respect and their dignity was maintained. People were supported sensitively with their personal care needs and support was offered discretely. We did hear some staff using language which was not always respectful such as referring to people who needed two staff to support them as 'doubles' . We also heard members of staff referring to people by their room numbers rather than their names. For example one staff member said, "[I've] got to feed numbers x and y" We brought this to the attention of the registered manager.

We also witnessed an incident where a person was given a change of dressing in the middle of the staff office. This was carried out by a district nurse but no staff member intervened or appeared to consider this undignified for the person concerned. We noted that personal information about people was openly discussed in this office, regardless of who was in the office. One person who used the service had a suspected urinary tract infection and this was discussed while a visitor was present. We also saw that another visitor popped in to ask to be informed when their friend passed away. Staff did not take the person to a more private room to discuss the matter in confidence.

The service had procedures in place relating to support and care for people at the end of their life. However staff had not received end of life training and people's wishes regarding the end of their life had not always been documented. For example we saw that two people had Do Not Attempt Resuscitation (DNAR) orders in place but there was no evidence this had been discussed with them or their relatives and their advanced care plan discussion documents were blank. This document is intended to capture people's wishes for the end of their life.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed before they moved into the service to establish if the service was suitable for them. Once people started to use the service their assessed needs were drawn up into a care plan. Care plans set out people's choices and preferences and built up a picture of how each person wished to receive their care. We found that people's particular likes, dislikes and preferred routines were not always well documented in their care plans. We saw that some plans contained information about how people liked to receive their care, including personal care, but in others there was no information about this.

We found that additional information was held in the activity assessments which had been carried out by the activity coordinators. However it was not clear that these assessments were accessible to all staff as they were not stored with the main care records and it was not clear how agency staff would be aware of them. Care plan summaries were in place. These provided a useful pen portrait of people's care needs but these were not detailed.

We found that where care plans did clearly identify people's these were not always met. For example one person's care plan identified that their church was very important to them but there was no further recording about this. This person had been unwell and, following a hospital discharge, was being nursed in bed. Their care plan did not contain any information about how staff should attempt to meet their emotional and psychological needs and contained no information about whether they were happy to receive personal care from both male and female staff.

We were concerned about the way the service provided care to some people following their discharge from hospital. Although an assessment was carried out before the person was admitted back into the service we found that care plans were not always updated at the same time. Care staff also told us that they did not have time to read people's care plans. This meant we could not be assured that all staff were aware of a person's current needs.

For example we saw that one person's care plan still stated that their dependency score was low even though they now required the assistance of two staff to meet their care needs. The person had not been weighed on their return from hospital and so the service did not have a baseline weight to refer to, in order to effectively monitor the person's weight. The person's care plan stated they were mobile even though they were no longer independently mobile. A clear change of need had occurred for this person but this was not reflected in their records. Given the high use of agency staff who would not be familiar with people's individual needs and the difficulty of finding staff to ask advice, this was a concern for us.

People who used the service were supported to follow their own interests and hobbies. The service provided a range of activities and occupation for people. We observed people helping to lay the table, visiting the hairdresser and 20 people took part in a quiz. A gentle exercise class took place and one person told us, "They have an artist comes in and we do painting and two ladies who are very nice do lots of lovely things – seasonal decorations. Guests come in for a lot of things like singing and a choir". Another person said, "It is fairly easy going her and we are entertained a lot. There are lovely gardens and I walk there every

day".

The service had three activity co-ordinators who worked Monday to Friday only which meant that there was little for people to do at weekends. Whilst there seemed to be a variety of things for people to do if they were independently mobile and well enough to attend one of the sessions, we could not see that there was much one to one provision for those who spent a lot of time in their rooms. Staff told us that those people who chose to stay in their rooms received a one to one visit at least once a week but records we checked did not confirm this. One person had no record of a visit in the last ten days. Another person who was totally dependent on staff support to take part in any activity, said, "There's nothing to do but you get used to it after a while". Staff also commented on the lack of provision for less able people. One said, "They don't always include difficult people" and another stated, "The activities meet the needs of some people – the more able".

There was a complaints policy and procedure in place. People told us they knew how to make a complaint if they needed to. One person who used the service told us, "Any complaints I would go to the lady in the office – you can talk to her". A relative commented, "I did have a concern once and it was sorted out straightaway". Another relative told us how they had raised a concern at a residents and relatives meeting about food trollies blocking the corridors. The matter had been dealt with straight afterwards.

Seven complaints had been logged in total since our last inspection. The records did not all contain the original complaint as some were responses to concerns raised informally. We saw that one person had complained about the loud call ball which was located just outside their room. The bell had been moved to another location. A formal complaint about the food had been responded to promptly and to the person's satisfaction. Each issue had been investigated and responded to in writing by the registered manager or the operations director. One response referred to the complainant wishing to have a response from the operations director but this was not present.

Requires Improvement

Is the service well-led?

Our findings

We found that records were not able to be produced quickly, were not stored confidentially in all cases and sometimes contained conflicting and out of date information. We saw numerous examples of repositioning charts which had not been fully completed or which did not contain clear information about exactly how and how often the person should be repositioned. This meant we could not be assured that people were receiving the correct care to prevent them developing pressure ulcers.

We noted that one person's care plan contained an MCA assessment which stated that they were unable to make decisions about the prevention of pressure ulcers. The whiteboard in the office stated that they should be repositioned every two hours but there was no repositioning chart in their room and they, and staff, told us they were able to move about in the bed and reposition themselves. Other records contained conflicting information. For example one person's daily notes stated that they had eaten and drunk well but their food and fluid charts stated they had not. This meant records were not clear which had the potential to place people at risk.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 17 – 1, 2 (c).

The service faced a number of challenges and in recent months the registered manager had received little support in dealing with these. A deputy had been appointed but had quickly left and there had been no management team consistently in place for over a year. At the time of our inspection a new regional manager, who had been in post a few weeks, was providing guidance and support to the registered manager. They had clearly identified the issues facing the service and had already begun to help the registered manager put new strategies in place. They were able to base themselves at the service two days a week and were spending a full week at the service when we carried out our inspection. They had no prior warning of our inspection. We spoke to members of the local authority safeguarding team and found that they also felt that the regional manager showed a real commitment to improving the service.

Many of the issues of poor practice identified at this inspection were linked to staffing concerns at the service. The management team were clear about the challenges facing them and were concentrating on improving call bell response times, a better deployment of staff within the service and the culture within the staff team. They had identified that they needed a second office for care staff and were splitting the service into two teams. This was designed to ensure that staff were not all congregating in the downstairs office, well away from some parts of the service. The regional manager had plans to improve the lines of accountability within the staff team to improve the performance of the team and to ensure staff could escalate concerns more easily and effectively.

We received mixed feedback regarding how open the culture of the service was and how transparent. Some people who used the service, and their relatives, praised how accessible the manager was and how responsive. One relative said, "I have not needed to speak to the manager but everyone is approachable".

Feedback from staff was more negative and overall staff did not feel supported by the manager and did not feel that their concerns were listened to. We received comments such as, "They don't listen and we feel a bit bullied" and, "We are not kept informed of new staffing and you don't see management unless you are in trouble". Another staff member said, "The manager is not approachable. She does not have time for me" while a fourth said, "I do feel I have the training I need, there's just no support". The staff culture was not healthy and senior staff were felt to spend a lot of time in the office rather than providing care and this is what we also observed. The layout of the building and location of the office made this issue more significant.

Staff meetings were held regularly and gave staff an opportunity to provide feedback and ask questions. We saw the minutes of the latest meetings for all the various staff teams although we did note that only eight staff had been able to attend the care staff meeting. Minutes of the meetings were made available to others.

Surveys and questionnaires had not been sent out recently to gauge feedback from the people who used the service or their relatives, although people told us they felt they were able to do this informally with staff.

There were systems to monitor staff training but these had failed to address some gaps in staff training and the service had not responded to staff requests for particular training such as food hygiene and dementia. The manager did not have an overview of people's supervision sessions and so we could not be assured that staff were receiving appropriate supervision.

Audit systems were in place to assess and monitor the quality of the service provided. Audits and spot checks were carried out by the manager and senior staff and action taken where issues were highlighted. Audits of medicines, tissue viability and falls were carried out monthly by the senior care staff and an action plan was put in place following these. The registered manager understood their responsibilities and had sent us the required notifications when an accident or incident had occurred. Although systems were in place to monitor the quality and safety of the service they had not successfully identified and resolved many of the issues we found on inspection such as those relating to people's fluid intake.

We felt the management lacked a comprehensive oversight of the service and was perceived as being remote. The regional manager acknowledged this and was considering how best to address this. During our feedback we in turn acknowledged the honesty and integrity of the regional manager who accepted that the service had work to do to bring about the required improvements and was passionate about making positive changes. Whilst we were encouraged that both the regional manager and the registered manager had begun to consider the way forward we remained concerned about how the service would continue to operate in the interim period. For example, although it was a good step forward to split the care staff into two teams and introduce a second office base, at the time of our inspection they had been unable to agree on a suitable location.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure safe care and treatment was provided as risks to people's health and safety were not always assessed and action was not always taken to mitigate risks. (Regulation 12-1, 2 a, b). The provider also failed to ensure the safe management of medicines . (Regulation 12 – 1, 2 g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure that people's nutritional and hydration needs were met. (Regulation 14-1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 – 1, 2 (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient

numbers of suitably qualified, competent, skilled and experienced staff. (Regulation 18-1).