Akari Care Limited

Philips Court

Inspection report

Blubell Close
Sheriff Hill
Gateshead
Tyne and Wear
NE9 6RL

Tel: 01914910429

Date of inspection visit:
14 September 2017

Date of publication:
23 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection of Philip's Court took place on 14 September 2017. It was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

We last inspected the service on 2 February 2017 and found the provider was meeting the fundamental standards of relevant regulations. At that time we rated Philip's Court as 'Good' overall and good in all five domains. We carried out this inspection in response to concerns that local commissioners and healthcare professionals had raised following their visits. During our inspection on 14 September we identified shortfalls throughout the service and breaches of regulations.

Philips Court is a care home which provides nursing and residential care for up to 75 people. Care is primarily provided for older people, some of whom are living with dementia. There were 70 people using the service when we visited.

The home has not had a registered manager since 28 June 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had recruited a person to be the registered manager who had started working at the service at the end of August 2017.

We identified a number of health and safety risks such as a fire exit being blocked with mattresses and a fire exit route leading towards an un-railed path that was adjacent to a steep slope. The new manager immediately ensured the fire exits and courtyard were cleared of hazards before we left. The provider took action to ensure the fire exit route had appropriate railings in place.

Although the domestic staff tried their best to keep the service clean there were insufficient staff to do the day-to day work. We also saw that the laundry staff needed more support or better cleaning products. The new manager immediately organised for the service to be deep cleaned and the provider ensured cleaning products were effective and additional domestic staff were employed.

We found staff were not always aware of who needed their food and fluid intake monitoring. Additionally staff needed to improve the accuracy of their recording when monitoring peoples' fluid intake. The manager had identified this gap in practice and was in the process of ensuring staff monitored people and supported them to receive adequate food and fluid.

We found from the review of records that some people displayed behaviours that challenge but staff had not received training to deal with their behaviours safely and the actions they needed to take were not detailed in the care records. During the inspection the manager contacted the provider's training department and organised for staff to immediately receive 'safe holding' training.

Safeguarding and whistleblowing procedures were in place. We found that previously concerns and complaints had not always been dealt with in a meaningful manner and no process had been put in place to ensure the issues were not repeated. Staff had not always ensured concerns were reported to the manager as they only recorded the issues in the particular person's daily records. The new manager had started to address this matter.

People's care records were cumbersome and we found it difficult to get a sense of a person's needs. The lack of a detailed written assessment had contributed to the difficulties around developing the care records as an effective working tool.

Accidents and incidents were monitored, but we found improvements were needed around how the information was analysed and used. We also found that medicines were not always administered safely. The new manager took immediate action to address these matters.

The environment on the upstairs nursing unit was not user friendly and this was compounded by the centre of the unit having glass walls that looked over the downstairs unit. This had led to people's dignity being compromised and provided a stressful environment for people who lived with dementia. Following the inspection the provider confirmed that frosting had been put across the glass walls and they had brought forward their plan to complete a full refurbishment of this unit.

People's rights under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were protected but staff would benefit from more bespoke training around the completion of capacity assessments. Staff training and supervisions had not been kept up to date. We found that the manager and provider's training and development team were dealing with this issue.

Effective recruitment and selection procedures were undertaken before staff began work to ensure people's safety. However, the provider's process for monitoring agency staff needed to be more robust. During the inspection the manager put in place additional steps to ensure check the suitability of all agency staff who worked at the service and ensure they were safe to work with vulnerable adults.

We found that the previous manager had not ensured regular audits were completed. Also they had not ensured that the staff adopted practices which showed they took ownership for their actions or worked as a team. We discussed this with the manager and following the inspection they confirmed that they had taken proactive steps to improve the way in which the service operated.

Staff spoke with people in a kind and caring manner, but we found staff needed to improve how they engaged with people receiving one-to-one support.
Following the inspection we wrote to the provider and asked them to put measures in place to address these issues. The provider supplied a detailed action plan, which detailed all the measures they were taking to improve the service.

Prior to the inspection the new manager had commenced a complete review of the service and was in the process of working through an action plan they had developed. We found that they had identified the same concerns that we found and were starting to address them.

People who used the service and the staff we spoke with told us that there were enough staff on duty to meet people's needs. We also found there were sufficient staff on duty. We found a range of activities were available on the ground floor that people could access from the other units.

We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, maintaining people's privacy and dignity, providing personalised care and having good governance systems in place. You can see what action we told the registered provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 not ensured staff were trained to support people who presented with behaviours that challenge.

Risk assessments needed to be improved as did the practices staff adopted when administrating medicines.

Staff were knowledgeable in recognising signs of potential abuse and reported any concerns. However, previously some concerns had not been reported to the appropriate authority which placed people at risk. The new manager was taking action to rectify this issue.

Recruitment procedures were completed on permanently employed staff, but robust checks on agency staff had not taken place to ensure people's safety.

The service was not clean or well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received all the training and supervision they needed.

Staff had not received the support they needed to develop their skills around how to complete capacity assessments.

Food and fluids not being effectively monitored.

People were supported to access health professionals when needed.

Is the service caring?

Requires Improvement

The service is not always caring.

Staff spoke with people in a kind and caring manner, but we saw that they would not respond when some people called for help.

We found they needed to improve how they engaged with people who received one-to-one support.

Relatives told us they felt people generally received good care but improvements needed to be made to ensure people consistently received good care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were overly complicated and did not reflect sufficient detail for staff to meet people's individual needs.

People's needs were not comprehensively assessed.

Activities were available for people to take part in. People told us they were able to come and go as they liked. Staff supported people to make their decisions and choices.

There were opportunities for people to give their views about the home.

Complaints that had been made had not always been thoroughly investigated, but the manager was rectifying this issue.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not ensured the systems for assessing and monitoring the performance of the service were effective which placed people at risk.

The new manager was taking action to improve the operation of the service but further work was needed.

There was no registered manager at the service.

Philips Court

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 registered 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 unannounced inspection took place on 14 September 2017. The inspection team consisted of an inspector, a bank inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales.

Before the inspection we also reviewed reports from recent local authority contract monitoring visits.

During our inspection we spoke with nine people who used the service and seven relatives. We also carried out observations using 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 communicate with us. We also spoke with the manager, six nurses, two senior carers, 14 care staff, the cook, a domestic staff member and the activities coordinator.

We spent time with people in the communal areas of the home and observed how staff interacted and supported individuals. We observed the meal time experience and how staff engaged with people during activities. We looked at eight people's care records, four recruitment records and the staff training records, as well as records relating to the management of the service. We looked around the service and went into some people's bedrooms, all of the bathrooms and all of the communal areas.

Requires Improvement

Is the service safe?

Our findings

On the first floor of the home we looked at six people's bedrooms and en-suite bathrooms. Within three of these areas we found prescribed creams and ointments that could have placed people at risk if swallowed or applied to the wrong area of the body. For example, within an easily accessible cabinet within one bathroom we found Hydromol ointment (prescribed for the management of eczema) with an instruction to 'avoid eyes'. We observed that on occasions the medication trolley was left unattended and unlocked by staff for brief periods of time whilst they went to administer people's medicines. We saw staff left some boxes of people's medicine on top of the trolley and these were therefore easily accessible to anyone passing, which placed people at risk of accidentally ingesting them.

We also heard from a number of visitors that they had found loose tablets on bedside cabinets and on the floor. We heard from the visitors when this had been reported to nurses no action appeared to be taken to investigate the concerns. We discussed this with the manager who took action to investigate this issue and ensure staff locked the medicine trolley when they were administering medicines to people in communal areas.

We found appropriate standards of cleanliness and hygiene in relation to the premises were not maintained. The plastic covering on some of the mattresses in people's bedrooms were torn and therefore could not be cleaned effectively. We found that the manager had identified these concerns and in the previous weeks had reviewed and replaced a number of mattresses. They confirmed this was an on-going process and said they expected that in the next few weeks all of the defective mattresses and plastic covers would have been replaced.

We found the provider had not ensured that the staff adopted practices that showed they took ownership for their actions. For instance, we saw staff were very role specific. Even though some cushions were visibly covered in dirt the care staff left them in situ and these were only removed by the domestic staff member (at least two hours after we and the staff first saw them).

Although the domestic staff tried their best to keep the home clean there were insufficient staff to do the day-to day work. It was evident that the allocated 'one day a week' for deep cleaning was insufficient to ensure the cleanliness of the service was effectively managed. We found all areas of the home needed an immediate deep clean. We saw that the laundry staff needed more support or better cleaning products. The manager organised for an immediate deep clean of the service and requested that additional domestic staff were employed. At the inspection the manager confirmed that the provider had agreed to this action.

In the internal courtyard we also found; broken furniture, food remnants on a table, a partly consumed bowl of cereal, cigarette ends and empty packets, a piece of wood with a screw protruding out, a steel delivery cage on wheels full of artificial turf, a dismantled gazebo in the corner, several trip hazards and rubbish strewn around the garden. We also found that a fire exit was being blocked with mattresses and a fire exit route lead to an un-railed path that was adjacent to a steep slope. We discussed this with the manager who immediately went out and removed the hazardous items. Following the inspection the provider confirmed

they were taking action to put handrails in place by the fire exit route.

We found from our review of one person's care records and discussions with staff, that at times, four staff were needed to support the individual due to their level of distress and agitation. Staff had not received training to do this safely. We discussed this with the manager and they immediately organised for training to be provided. The care records did not detail the actions staff needed to take. Risks posed to visitors and potentially staff when people displayed behaviours that challenged were not documented, so management strategies were not outlined. We discussed this with the manager who showed us the new documentation they were working on, which aimed to address this issue.

We saw in care records related to monitoring diabetes no baseline sugar levels were recorded or information about what staff should do if these were high or low. Additionally information was not available to show when subcutaneous fluids were given, which meant staff could not monitor if there was an increase in people's reluctance to drink. We discussed this with the manager and provider who took action to ensure the staff were able to detail this information.

We found Personal Emergency Evacuation Plans (PEEPs) were not available for all of the people living at the service and of those in place, many were out of date. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

We found the provider needed to ensure accident analysis covered the broader picture for people so reasons as to why someone was experiencing an increase in falls at specific times could be identified and explored. In addition, such an analysis would enable consideration to be given to proving additional aides such as pressure mats and additional staff support.

We discussed all these concerns with the manager who told us they would take immediate action to rectify the issues. Following the inspection the provider submitted an action plan, which detailed how these issues had either already been addressed, or how they would be addressed. This plan provided an appropriate timescale for works to be completed.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that carpets in communal areas and in people's bedrooms were stained and badly marked. We saw that the paintwork on every person's bedroom door was chipped and the walls in the corridors were also marked throughout. In one person's bedroom a curtain had been ripped loose from the rail, in another person's bedroom we saw the radiator covering was loose and the side was hanging off exposing sharp edges. Poor maintenance of bedrooms may have discouraged some people living with dementia from using these areas and have had a negative impact upon their ability to remain independent.

During the inspection we saw that items were inappropriately stored on the top of people's wardrobes or in their en-suite toilets. For example a large picture had been placed on top of the wardrobe and could have easily toppled off. In a lounge area where, as a result of their dementia people could become agitated, they had access to a shelf containing a number of glass bottles. There was also a large glass fish tank where people assessed as at high risk of falls were living. There were no risk assessments in place to show that these hazards had been considered. We discussed these issues with the manager who took immediate action to ensure staff removed risk items and risk assessments were completed.

The manager and provider confirmed that plans were in place to complete a full refurbishment of the home and that this would be commenced before the end of the year. We noted action was being taking to repair 'out of order' showers and bathrooms.

This is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions. We confirmed checks from the Nursing and Midwifery Council (NMC) for qualified nurses were up to date. However, we found the provider had not ensured effective monitoring checks were completed to ensure that agency nurses remained registered with the Nursing Midwifery Council, they had the right to work in the United Kingdom, and they had completed appropriate training. We discussed this with the manager who immediately altered their processes to ensure that on each occasion agency staff were to be used, these checks were completed.

People had mixed views about the service. The people who used the service on the whole felt more satisfied than their relatives about the care being provided. One person said, "Oh yes, they are really good in here, I get well looked after." Another person said, "There certainly seems plenty of staff about." A third person said, "I feel very safe, I've never been happier living anywhere else."

Relatives commented, "[Person's name] has been given other people's clothes, which I'm not happy about."; "Dead flowers can be left a fortnight or so with the dead flowers and water unchanged"; "I've had to ask them to cut my relatives nails and keep them clean"; "My relative was in the lounge a while ago and was slowly falling out of her chair. She had to ask for assistance even though staff were present"; and "Since I've been visiting [person's name] in February I've noticed a lot of staff around, however there was an incident in March this year when [person's name] somehow became locked in their bedroom. I wasn't happy with the explanation given for this as the young female carer I spoke to said [person's name] had just popped in the room with a cup of tea."

Staff understood what actions they would need to take if they had any safeguarding concerns. Safeguarding and whistleblowing policies were in place. However, we found that historically the provider had not always notified us or the local authority when safeguarding concerns had been raised. We found that the new manager had been reviewing all of the available information and had commenced sending in retrospective notifications to the Commission, and alerts to the local authority, for incidents that had not previously been reported externally. We have taken this remedial action into account when considering our regulatory response to this failing.

We found information about people's needs had been used to determine the number of care staff needed to support people safely. We found that there were enough care staff to meet people's needs. For the 70 people who lived at the service there were four nurses (until 2pm and then three nurses), a senior and 16 care staff (which included care staff providing one-to-one support) during the day. Overnight there were two nurses and eight care staff. In addition to the manager and deputy manager were on duty during the week.

Requires Improvement

Is the service effective?

Our findings

We looked at eight people's care records and found these individuals tended to become agitated and display behaviours that may challenge. Each person had been prescribed 'as and when required' medication to be administered when they became distressed. There was no indication in the care records of the nature and intensity of behaviours which would indicate that staff needed to administer this medication. Also there was no step by step guidance to inform staff about what they should do to support people in alternative ways rather than administering medication. The nurses were not always aware of who received this type of medicine. We discussed this with the manager who showed us the new 'as required' protocols they were developing, which were much clearer.

We found staff were not always ensuring people received meals and drinks in order to support their nutritional needs. Guidance and advice provided by healthcare professionals was not always acted upon by the care staff. For example, we saw that one person had been provided with a detailed nutritional support plan from the local NHS Trust but there was no care plan in place to make sure this guidance was put into practice in the care home. We also saw staff placed sandwiches in one person's hands outside of the dining room and then let them walk off, but they never checked if they had eaten the food. We had earlier in the day found bread stuffed down the back of a radiator so could not be confident the people given their food in this manner would actually eat it. We discussed this with the new manager who took immediate action and confirmed in their action plan that this was regularly discussed with staff and the dining experience was regularly reviewed.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff had received training in the Mental Capacity Act 2005 and DoLS authorisation. Staff appropriately recognised when people had or did not have the capacity to make decisions but would benefit from more bespoke training around how they were supposed to complete capacity assessments. The available capacity assessment forms did not support staff to clearly identify, which decision the person was being asked to make. The 'best interests' decision forms we saw did not encourage staff to identify who out of a

multidisciplinary team had been involved in the discussion. The provider's care record template did not prompt staff to establish who had enacted lasting power of attorney for care, welfare and finance and if the Court of Protection had appointed anyone to act as an individual's deputy.

The new manager told us that although the supervisory body had authorised DoLS, none of the associated paperwork was at the service. We noted from our review of care records that one person had challenged their DoLS authorisation at the Court of Protection in June 2016 but there was no information to outline the outcome or how the restrictions on their liberty were now managed. We could not establish if a subsequent renewal of DoLS authorisation had been agreed by the Court of Protection, but noted if they had upheld this decision the authorisation had expired in December 2016. The manager confirmed that they were taking action to follow up missing information about the Court of Protection outcome and DoLS authorisations. They had phoned the supervisory body to find out what conditions had been imposed via the DoLS authorisations and documented these whilst they awaited the paperwork in order to ensure staff adhered to any conditions.

Staff had been trained to meet people's care and support needs in topics such as working with people who lived with dementia. Records showed staff had received training in subjects that the provider deemed to be mandatory, such as moving and handling, health and safety, safeguarding and first aid that needed to be updated. Mandatory training and updates were deemed by the provider to be necessary to support people safely. We found that in the recent months, staff training had not been kept up to date. Also the custom and practice of the staff needed to be reviewed within this process. However, we found that the manager and provider's training and development team were dealing with this issue.

Staff had been supported with regular supervisions and appraisals until the previous manager left the service, but in recent months, these had lapsed. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The new manager was in the process of designing a new plan to ensure all of the staff received regular supervision and appraisal.

We found that the systems in place for monitoring delivery of training, identifying gaps in staff knowledge and records related to capacity assessments and best interest decision making, had not been effective up until the time of our inspection.

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

We saw that the physical environment throughout the home did not reflect best practice in dementia care. Other than the pictures of toilets, lounges and dining areas, placed on doors, there was no evidence of adaptations to the environment to show good practice guidelines had been put into practice. Some bedroom doors had a recent photograph of the person. Due to the nature of dementia people may not recognise themselves as they are now and therefore this approach is not always helpful in assisting people to find their personal space. There was no evidence of any other method being used to help people to find their personal room. We also found a sign on a corridor wall with the words "seaside café now open." The sign was directing people to a dead end, which is poor practice in a dementia care environment. The manager was aware that the environment needed to be adapted to ensure it was dementia-friendly and we found this formed a part of the refurbishment plan.

One person said, "They (staff) seem to know what they are doing." Another person said, "I think they are good, one person bumped her mouth and the staff were there straight away giving first aid."

Relatives told us, "Pasta and sandwiches seem to be the order of the day here" and "[person's name] has been given food I expressly said they did not like." Another person said, "The food looks nice, they bake cakes for birthdays." One relative informed us that staff had reported a number of incidents between their relative and other people who used the service during mealtimes. In response they had requested that the relative had their meals separately, as they found the general noise disturbs them, however they told us this had not yet happened.

We found there was only one choice of a cooked meal at lunchtime (sausage roll and beans) on two units. The alternative was sandwiches. But on another unit, as well as sandwiches soup was provided. Additionally some units had mid-morning and afternoon drinks and snacks such as biscuits and fruit. Other units did not have these refreshments. We could not establish why there was a difference. We found the pureed version of the sausage roll and beans was visually very unappetising. The manager did assure us that action was being taken to improve menus, staff practices and the available choices.

During the inspection we saw people had access to other healthcare professionals to support their general health and wellbeing. For example, we saw staff had arranged for a taxi so that one person could visit the dentist of their choice. A chiropodist was also visiting the home during our inspection and a routine review meeting was taking place with the social worker to discuss one person's health care needs. We saw advice had been sought from other health care professionals when needed, such as a dieticians and psychologists.

Requires Improvement

Is the service caring?

Our findings

We spent time observing care practices on the first floor of the home, which supported people who were living with dementia. Although staff generally appeared respectful when interacting with people who used the service they did not always respond to peoples' requests for support. We saw on one occasion in a communal lounge there were a number of staff present and one person tried several times to attract their attention, but staff did not react to their requests. On another occasion one person was clearly upset and concerned about their well-being. We saw staff walked past this person ignoring their needs. On both occasions it was necessary for the inspection team to intervene and ask staff to respond.

We heard a person ask for a drink. Rather than respond to this request the member of staff said "The trolley will be around in five minutes." We found staff needed to improve how they engaged with people receiving one-to-one support, as they did not use this time to engage people in activity or even conversation. Staff merely stood next to the person keeping an eye on them.

Staff did not demonstrate an understanding of the diverse needs of people they were supporting. For example, one person was kneeling on the floor in the corridor and although staff were in this area, they did not intervene until members of the inspection team brought this to their attention. It stated in the person's care plan if they were found kneeling on the floor 'staff are to ask [name of person] if they would like to stand and take them to a safe environment.' This guidance was not followed by staff. On another occasion we watched staff place the person's meal on the floor in the corridor in front of them because the person did not want to get up off the floor and staff did not appear to know what else to do to support this individual. We observed one person sitting on a chair with their continence aid visible. They were left in this position for over an hour before lunch.

These observations and inappropriate staff practice demonstrated people's dignity and wellbeing was not promoted. We discussed this with the manager who recognised that the culture of the service needed to change. They outlined how staff had previously been encouraged to focus on tasks rather than the people they were supporting and it was their intention to ensure the service became person-centred.

The environment on the nursing units was not designed to support people's privacy and dignity. The current clear glass, at the centre of the upstairs unit, which overlooked the main corridor of the nursing unit below, posed perceptual risks to people, as you could see directly to the floor below and this was vertigo-inducing. It allowed people's dignity to be compromised, as people looking up could inadvertently see up people's clothes. It also cause distress for some of the people, as they could see their relatives who may have been visiting the home for a different reason and they were upset they were not visiting them. We were told material had been purchased to create a frosting effect on the glass walls on the upstairs floor.

We highlighted to the manager that more needed to be done to ensure the environment was dementia-friendly. The manager acknowledged this deficit and confirmed that within the refurbishment programme work was being completed to create an environment that would be suitable for people living with dementia.

This is a breach of Regulation 10 (Dignity and respect) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider had not ensured systems were in place to support staff to provide a personalised caring service, as the environment was dirty and staff had not received sufficient training to ensure they delivered a dignified and respectful service.

The majority of people we spoke with felt they were well cared for and staff treated them with respect. One person said "The staff are really nice, you couldn't get any better really, I've got no complaints." Another person said, "I get respect." Another person said, "The staff are wonderful, caring and patient."

Relatives told us they thought the staff were very kind. One relative said, "I always find the staff are pleasant and they do seem to know people well." Another person told us, "Staff don't have time to sit and talk, they are just too stretched and too under-staffed to talk."

We visited the service early in the morning and found that people were able to get up when they wanted. One staff member told us, "We only assist people to get dressed if they are clear about the fact they want to get up." When staff spoke with people they were friendly and professional.

We saw that information about advocacy services was available to people and when needed the staff enabled people to access these services. Advocates help to ensure that people's views and preferences are heard where they are unable to articulate and express their own views.

At the time of our inspection people were receiving end of life care, when this was appropriate. Staff understood the actions they needed to take to ensure pain relief medicines were available and used in line with expected practice. Care records contained evidence of discussions with people about end of life care so that they could be supported to stay at the service if they wished.

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care records and found there were 'behaviour' care plans, which provided basic information about the actions staff should take to support people at times when they became agitated, distressed or displayed behaviours that may challenge. However, there was very little information in the care plans to describe possible triggers to the behaviours. Nor was there a detailed description of the types of behaviours people exhibited or step by step guidance to inform staff about what they should do to support people to reduce their distress or what to do if staff needed to physically intervene.

People who were identified to be at risk in respect of different aspects of their daily living had plans of care in place, such as plans for ensuring action was taken to safely assist people to eat. However, the 'Client's General Risk Assessment' form was basic and only listed four specific areas, with one section for 'other' risks. We accepted that a new care record template was being designed and in practice staff were supporting people to manage risks. However, action was needed to ensure the current records were organised so immediate risks such as choking and falls were not lost amongst the paperwork.

We discussed these issues with the manager and they showed us new care plan documentation they had developed for working with people who displayed behaviours that may challenge. They told us the provider had agreed to this being used at the service and showed us one of the new plans they had developed for a person with very complex needs. We found this more informative and useful than the existing care records. The manager intended to roll this document out over the next few weeks and ensure staff recorded detailed information about how to work with the people who used the service.

Charts were used to document peoples' change of position and their food and hydration intake but staff had not ensured people's fluid intake was recorded.

This is a breach of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that the provider was also in the process of introducing a new set of care records. However, current records needed to be organised so immediate risks and changes in people's presenting needs were not lost amongst the paperwork, and assessment information contained detailed information about people's needs.

The personal information for each individual was quite varied and not consistently presented. For example, one person had a laminated 'pen-picture' whilst others did not. Some people's care plans were written in the first person singular ('I') but had not been signed or written by the person concerned, which was misleading.

We discussed with the manager how the assessments could be enhanced. The provider only supplied a very limited record for staff to record their full assessment of a person following admission. Other documents they relied upon were tick box assessment forms, which did not allow staff to describe how the person was

impacted by their condition. The lack of a full assessment meant crucial information about people's past experiences and risk history was unavailable. This lack of a comprehensive assessment had led staff to using care plans as the assessment tool and meant that numerous care plans were generated. The use of care plans in this manner meant the person's priority needs were lost and staff would find it difficult to readily identify when care records were updated. The manager accepted this was a gap and agreed to take action to develop an appropriate tool.

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

We spoke with a visiting relative who told us they felt able to complain to the staff if they had any concerns. However, we found that complaints made previously by relatives had not always been acted upon or reported to the manager. For example, in one person's 'relative's communication record' we saw the family had raised concerns about their family members care. There was no further information to show staff had acted upon or reported these concerns to the manager. We discussed this with the manager and they confirmed they were speaking to relatives and reviewing all of the records to ensure all concerns were identified and investigated. One of the relatives confirmed that this was the case.

On the first floor of the service where people who were living with dementia were supported and we saw that four people received one-to-one support from staff. Despite the high staffing levels we saw no evidence of therapeutic activities taking place with these people. Staff tended to observe people rather than encouraging individuals to engage in activities, which would be interesting or stimulating for them. We discussed the lack of stimulation and why people with one-to-one weren't supported to go out into the garden, join in activities or access the local community. The staff and manager told us they would look at the best and most therapeutic way to use this resource.

People and relatives told us that the activities coordinator was good at their job and really brought the home to life. People said, "I go to them all, I join in everything, my favourite is singing, I like singing because I know all the songs." Another person stated, "I really like all the activities. They bring pets into the home and we have rabbits and chickens in the garden." A relative said, "The staff are smashing and treat [person's name] the way he likes, nothing is too much trouble." Another relative said, "[Person's name] goes down to the activities quite a bit, he tells me he enjoys it."

We found people on the ground floor were engaged in meaningful occupation and the activities coordinator had tailored the programme of activity to stimulate each person and entertain individuals. The activities coordinator was enthusiastic and we saw they organised group events, which people from across the home joined plus activities for individuals such as going for walks. The service also had a courtyard garden that was occupied in the centre by chickens and rabbits. People spoke very positively about this resource and enjoyed feeding the animals independently.

Requires Improvement

Is the service well-led?

Our findings

The service had a new manager who had been in post for four weeks. Although they had been reviewing the service and making changes we saw little evidence of good governance or leadership being in place beforehand. We found prior to the manager taking up their post, there was limited evidence to show that risk assessments to identify potential hazards to the health, safety and welfare of people who used the service had been completed.

The provider had recently introduced a new computerised system [Care Block] for monitoring the performance of the service; we found staff were still in the process of imputing information. Thus, they had ceased completing many of the paper-based audits and were transposing information onto Care Block. This meant during this period of transition the provider could not be assured that oversight of the service remained robust.

We found the quality assurance procedures in place lacked 'rigour'. For instance, the tool the provider had supplied for monitoring accidents and incident did not assist staff to look at wider issues than a particular fall, so they were not considering if there were patterns or trends. We found the quality monitoring systems had not picked up that vetting system for agency staff was not robust enough or that care records were not appropriately completed.

Although the staffing levels in the service were good, staff time was not organised effectively to meet people's needs, for example there was lack of therapeutic activities to provide stimulation and interest to people. Also a review of staff practices and the culture of the service had not occurred, which led to people being ignored by care staff. Also the lack of oversight led to the issues around the cleanliness and general poor state of repair of the building and the poor quality of people's care plans. This demonstrated that there had been a clear lack of regular auditing of standards of care.

We looked at how the provider monitored and checked medicines to make sure they were being handled properly and that systems were safe. We found that the previous manager had not completed monthly audits so any areas for improvements had not been highlighted. The new manager had completed a review and identified areas that needed to be addressed.

We found that one person, who was assessed as requiring one-to-one support during the day until 12am, could also be awake during the night. For example, we found an entry in their daily records, which said '[name of person] had been up a few times during the night' and another entry stated; 'very agitated but settled down' and on a third entry recorded 'unsettled [name of person] has had 1:1 until 12.am.' There was no evidence that staffing levels had been reviewed to ensure the person remained safe during the night if they awoke and got up. The provider had not picked these issues up. We discussed this with the manager who said they would take prompt action to ensure sufficient staff were available to provide the one-to-one support the person needed. We noted that the person had not come to any harm and were assured by the manager's actions.

We were alerted to safeguarding concerns by the local authority that had been reported to them, not by the service informing us. The provider and staff had not notified us appropriately about incidents and events at the service. We discussed this with the manager and found following the inspection there was an increase in reporting. We are dealing with this matter outside of the inspection process.

We found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and the above breach of the Care Quality Commission (Registration) Regulations 2009. We found that the previous manager and the provider through their monthly visits to the service had not identified these shortfalls and addressed them.

Following the inspection we wrote to the provider and asked them to provide a detailed improvement plan outlining how these issues would be rectified. They provided a detailed action plan that showed many of the concerns were addressed immediately following our inspection and others were in hand. We found that the provider set appropriate timescales for dealing with the concerns.

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

The manager took up their post at the end of August 2017 and told us they would be applying to become the registered manager. Staff provided positive feedback about the new manager. One person told us, "[Manager] is very good and does listen to you."

The manager told us that the provider was supportive of the action they were taking and was providing them with the resources to make the much needed improvements at the service. Since coming into post the manager had been able to increase the number of hours nurses worked, made the deputy manager supernumerary, given the nursing team the autonomy to make changes and had started to introduce new care record documentation, which was more effective. We found that the manager had identified the breaches of regulation that we identified at our visit and they had also started to address gaps in practice. They had developed an action plan, which we found had been designed to address the issues.

We spoke with the manager about how they ensured sufficient staff were on duty. They told us that staffing levels were regularly assessed using the providers care home equation for safe staff. They told us that this staffing equation provided them with a baseline number of staff required each day. In addition to this they were able to provide further staff when required to meet people's needs. The manager told us that by using this tool they had been able to evidence that more nursing staff were needed and found after raising this with the provider the number of nurses had been increased to four during the day.

All of the staff and visitors we spoke with were positive about the steps the new manager had taken and the improvements they were witnessing. They found their hands on approach very refreshing and felt they provided more support and enabled the nurses to undertake their clinical tasks.

We also found the courtyard with chickens, rabbits and guinea pigs was accessible to people who used the service, and was an extremely beneficial resource that if used more would be a valuable therapeutic aid. The manager told us that since starting work at the service they had obtained £11,000 in grants to make improvements to this environment.

The manager was in the process of setting up meetings with all the staff so they could give their views about the service. We saw that the staff team were reflective and all looked at how they could tailor their practice to ensure that the care delivered was completely person centred.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider was not ensuring staff always treated people with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring that processes adopted within the service enabled staff to appropriately assess the risks to the health and safety of people receiving care or treatment and to take action to mitigate any such risks. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises and equipment were not properly maintained or kept to a good standard of hygiene appropriate for the purposes for which they are being used and maintained. Regulation 15 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

Treatment of disease, disorder or injury

governance

The provider had not established systems or processes, which operated effectively to ensure compliance with the legal requirements.

Regulation 17 (1)