Barchester Healthcare Homes Limited

Austen House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28, 29 and 31 August 2018. It was unannounced on the first day and announced on the second and third days. The inspector was supported by a bank inspector with experience of nursing and dementia care on the first day of the inspection.

Austen House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Austen House provides personal care and nursing to up to 79 people in four units. The people supported have nursing needs and may be living with various types of dementia. At the time of this inspection 71 people were receiving support.

The service is required to have a registered manager. 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 service has had seven registered managers since its registration in 2011. The most recent registered manager left in early August before this inspection. An experienced acting manager was in place from another of the provider's local services.

This inspection was brought forward in response to a series of safeguarding incidents, complaints from relatives and a service user, concerns raised by a recent whistle-blower and by the local authority. Concerns mainly centred around safeguarding, the provision of adequate fluids, pressure area care, staff conduct/approach and staffing levels/deployment.

People told us they now felt safe in the service. However, we found people may not always have been kept safe because the provider or manager had not always responded in a timely or effective way to address issues to reduce the risk of recurrence. We had not been able to fully evaluate the provider's investigative response to recent concerns, particularly about specific staff, because information we requested about these was not provided in a timely way.

People had further been put at risk of potential harm because of ongoing errors and omissions we found in medicines records. This was despite these issues having been highlighted previously within pharmacists reports and internal management monitoring.

People's safety was also potentially compromised because we found gaps in the recruitment records. This meant we could not be assured the required checks on the health, skills and previous conduct of staff recruited, had been verified to ensure they were suitable to provide safe care to people.

Staffing levels had recently been increased to address identified shortfalls which had led to gaps in care provision and some delays in receipt of care. Recruitment was ongoing to address the significant staff shortfalls which were being covered by agency staff in the interim.

It was not clear whether people had always received sufficient fluids to maintain wellbeing. Fluid intake records were poorly completed despite the issue having been identified previously by the local authority.

People's rights and freedom had not always been protected. Records of mental capacity assessments were not always present where Deprivation of Liberty Safeguards (DoLS) had been applied for. Records of best interest decisions and people's consent were sometimes incomplete or conflicted with their stated capacity. Some consent given by families was not backed up by evidence of power of attorney.

It was not clear that people's complaints had always been investigated thoroughly or resolved satisfactorily. Complaints records were incomplete and poorly maintained.

The activities provided by the service did not effectively meet people's individual and collective needs sufficiently. The acting manager was taking steps to address this.

Care records were not always sufficiently detailed. Daily records lacked detail about the meeting of people's social and emotional needs.

The service was non-compliant with the Accessible Information Standard. Suitable alternative versions of key documents were not yet available to meet the needs of individuals with sensory loss or other impairments.

Significant improvements had been noted since the recent arrival of the current acting manager. People felt the acting manager was approachable and was already addressing issues.

However, the service had not been sufficiently well led in the 12 months leading up to this inspection. Neither the previous registered manager nor the provider had exercised effective governance of the service over the previous 12 months, which had led to issues and shortfalls not being addressed effectively or in a timely way. The previous registered manager had failed to report to the CQC the outcome of all DoLS applications and had not understood her responsibilities under Duty of Candour.
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The recently appointed acting manager had begun to establish in-house monitoring and audit systems to help identify the areas for improvement with input from the provider's clinical support and dementia specialist teams.

People and relatives' views about the service had been sought in the previous 12 months by means of a survey, with mostly positive results.

Staff received support through one-to-one or group supervision, regular meetings and periodic performance appraisal.

People were treated with respect and dignity by the staff. Staff interacted regularly with people and knew them and their needs well. People's gender preferences were met wherever possible.

People told us the current staff were caring and treated them kindly although some concerns were raised about some previous agency staff. People and relatives felt involved indecision making about care. People

felt the current staff and management were responsive to their needs.

Effective general healthcare support was provided and external healthcare practitioners were consulted when required.

People felt the effectiveness of the service had improved since the acting manager started.

We identified five breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) and one breach of the Care Quality Commission (Registration) Regulations 2009. Details of the action we have taken are at the end of the full report.

We also made a recommendation that the provider should refer to the guidance available regarding the 'Accessible Information Standard' and address their current non-compliance as appropriate.

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's response to safeguarding and other concerns had not always been effective or timely enough to reduce the risk of recurrence.

We could not be sure people had always been kept safe. We were unable to evaluate the provider's investigations of concerns about specific staff because requested information was not provided in a timely way.

People had been put at risk of potential harm because of ongoing errors and omissions in medicines records.

People's safety was potentially compromised because we found gaps in recruitment records indicating failure to follow the required process.

Staffing levels had recently been increased to address identified shortfalls. Recruitment was ongoing to address significant staff shortfalls, being covered by agency staff in the interim.

People told us they now felt safe in the service.

Is the service effective?

Requires Improvement

The service was not always effective.

We could not be sure people had always received sufficient fluids to maintain wellbeing. Fluid intake records remained inconsistent and incomplete despite the issue having been identified more than once.

People's rights and freedom had not been protected. Records of mental capacity assessment, Deprivation of Liberty Safeguards (DoLS), best interest decisions and consent were sometimes incomplete or conflicting.

Effective general healthcare support was provided and external healthcare practitioners were consulted when required.

People felt the service had improved since the acting manager started.

Staff received support through one-to-one or group supervision, regular meetings and periodic performance appraisal.

Is the service caring?

Good

The service was caring.

People told us the current staff were caring and treated them kindly. People and relatives felt involved in decision making about care.

People's gender preferences were met wherever possible and they were treated with respect and dignity by staff.

Staff interacted regularly with people and knew them and their needs well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

It was not clear from records that people's complaints had always been investigated thoroughly or resolved satisfactorily.

The activities provided did not meet people's individual and collective needs sufficiently well although work was under way to address this.

Care records contained variable levels of information about individuals needs although most were sufficiently detailed. Daily records lacked detail about the meeting of people's social and emotional needs.

The service was non-compliant with the Accessible Information Standard. Suitable alternative versions of key documents were not available to meet the needs of individuals with sensory loss or other impairments.

People felt current staff and management were responsive to their needs.

Is the service well-led?

Requires Improvement

The service had not been sufficiently well led.

The provider had not exercised effective governance over the

service over the previous 12 months, which had led to issues and shortfalls not being addressed effectively or in a timely way.

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The acting manager had begun to establish in-house monitoring and audit systems to help identify the areas for improvement with input from the provider's clinical support and dementia specialist teams.

The previous registered manager failed to report to the CQC the outcome of all DoLS applications and had not understood her responsibilities under Duty of Candour.

People and relatives' views about the service had been sought in the previous 12 months by means of a survey, with mostly positive results.

Significant improvements had been noted since the recent arrival of the current acting manager. People felt the acting manager was approachable and was already addressing issues.

Austen House

Detailed findings

Background to this inspection

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

This inspection was brought forward in response to a series of safeguarding incidents, complaints from relatives and a service user, concerns raised by a recent whistle-blower and by the local authority. Concerns mainly centred around safeguarding, the provision of adequate fluids, pressure area care, staff conduct/approach and staffing levels/deployment. The service has had seven registered managers since its registration in 2011. The most recent registered manager left the service in August 2018, prior to this inspection. An experienced temporary manager had since been brought in by the provider from another of its services.

This inspection took place on 28, 29 and 31 August 2018. It was unannounced on the first day and announced on the second and third days. The inspector was supported by a bank inspector with experience of nursing and dementia care on the first day of the inspection.

The inspection had been brought forward so an up-to-date 'Provider Information Return' (PIR) was not available from the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We examined all the information we held about the service including safeguarding reports, information from a whistle blower, complaints and statutory notifications relating to the service. Notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke to four people using the service, four relatives and a visiting health professional. We also spoke with the acting manager, other members of the senior management team, a member of the provider's dementia team, three registered nurses and four care staff.

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who could not talk with us. SOFI observations were carried out in two

of the four units on the first day. We informally observed the care in communal areas throughout the three days of inspection and observed the meal-time support provided to people.

We looked at six care plans, other documents relating to people's care and a sample of other records to do with the operation of the service. These included, training and supervision records, medicines recording, management monitoring systems and action plans in response to the concerns raised about the service.

We requested the email contact details for local authority commissioners to seek their views on the service, however, the details were not provided before the report was drafted.

Requires Improvement

Is the service safe?

Our findings

One person we spoke with felt safe living at the home. They told us, "I like it here. The staff look after me really well". Another said, "I feel safe now, since the new manager came, he's great, I didn't before." They told us they had previously experienced poor manual handling particularly by some agency staff who could be rough and there had been too many agency staff. They said there was, "A good bunch here now." Another person said, "It was alright, but it's a hundred times better now." Relatives felt their family member was safe at the home. One told us, "I think [name] is very safe here. The care is good and there's always someone around to help them".

Staff had attended adult safeguarding training within the last year and understood the safeguarding procedure should they suspect abuse. One staff member told us, "We do get training every year so we know what to look for. I would report any abuse I saw to the manager. I know they would do something". A significant number of safeguarding events had arisen in the period leading up to this inspection, (22 safeguarding alerts in 12 months), including four regarding inappropriate staff conduct. Concerns had been raised by the local authority and a relative as well as by the service. A resident had personally raised one safeguarding concern.

The provider acknowledged responses to these issues had not always been sufficiently thorough and promises made about actions taken had not always been fulfilled. It was not clear sufficient governance had been exercised by the provider in learning from escalating concerns to reduce the risks to people of re-occurrence. Some management responses had not satisfactorily addressed the concerns raised. Staff suspensions had taken place, which had led to a range of outcomes, including resignation, disciplinary action, reinstatement and retraining. We asked the provider for information about the action taken in response to the various concerns about staff but this had not been provided at the point of drafting this report. It was therefore not possible to establish whether investigations had been sufficiently robust. Where the local authority had raised concerns about specific staff, the acting manager told us the actions taken had been reported back to the local authority. This is addressed within the Well Led domain.

Following the departure of the previous registered manager an experienced acting manager had been brought in from another service to manage Austen House until a new manager was recruited. The acting manager told us the service was currently also without a deputy manager or clinical lead although support was being provided by staff from another service pending interviews. One team leader had recently been promoted to senior team leader to improve the senior team. The acting manager was being supported by a range of in house specialists and senior management to address the identified issues. These included the provider's dementia specialist team who were undertaking a baseline audit of the service during our inspection. The local authority provided a detailed action plan identifying the necessary improvement areas and were carrying out a series of monitoring visits to monitor progress. A range of improvements had recently been seen. It remains to be seen whether the changes made will be sustained and this will be monitored by the local authority and The Care Quality Commission.

The acting manager told us manual handling refresher training had been booked for the week of the

inspection but was cancelled and would be re-booked as a priority. During this inspection we saw staff assisting people to move or transfer using a variety of hoists and stands. We noted there were enough staff do this safely and staff appeared competent in managing this. We saw those whose mobility was restricted, or were bedbound, had access to their call bells. Those who could not use their call bells, for example, after having suffered a stroke, were risk assessed and were monitored regularly to ensure they had access to staff should they need it.

Where people needed support to manage their behaviour, effective steps had not always been taken in a timely way to reduce the risk of harm to others. The acting manager said he planned to seek additional staff training on behavioural support skills so they were better equipped to do this. He planned for future admissions to be people with lower dependency levels to balance the range of needs across the service so staff were better able to meet everyone's needs.

People's care plans contained up to date and relevant information concerning the risks associated with movement. For example, there were manual handling assessments and bed rail risk assessments. The staff we spoke with were knowledgeable about individual people's needs in this regard. Other potential risks to people, for example from dehydration or malnutrition, were also risk assessed and a care plan put in place to address them. We did note that the air conditioning in one unit had been reported as out of order over several days during recent hot weather without any evidence of urgent action to obtain repair or a temporary alternative. Confirmation was provided following inspection that the air conditioning had been repaired.

The premises were purpose built and did not present significant difficulties in evacuating people in the event of an emergency. There were Personal Emergency Evacuation Plans (PEEP) in care plans which outlined how people could be evacuated or kept safe in the event of an emergency. The action plan from the in-house 'Fire Risk Assessment' identified one required action which was not recorded as having been done. The acting manager agreed to check this had been addressed and confirm this.

Available records suggested only ten staff had completed fire extinguisher training, in 2016. The acting manager agreed to check and report the current position regarding this training. Other aspects of fire safety monitoring were in place, based on the available records and regular fire drills had taken place. The alarm and detection system had been regularly serviced. Other safety checks such as water temperatures, gas safety, electrical testing, legionella testing, examination and servicing of lifts and hoists had all been carried out. The acting manager agreed to confirm whether the deficits identified in the lift servicing report had been addressed.

The service had an appropriately robust system of pre-appointment recruitment checks as required. However, we found some omissions in the records of six recent recruits and four of the external agency information sheets for staff supplied to the home. The missing items were a health check, application form, reference and some unexplained gaps in employment history. Some agency information sheets did not contain evidence of a current DBS criminal records check. The acting manager agreed to address these omissions. Updated agency staff information was supplied following the inspection. However, the forms provided still didn't give the date of the most recent DBS (criminal records) check, stating only the reference number.

Concerns about staffing levels and deployment had been raised by the local authority, a complainant and a whistle blower. Staffing levels were calculated using a dependency assessment tool and reported to the regional director daily. The acting manager acknowledged there had been occasions where staffing had fallen short of the assessed need prior to his appointment. Staffing levels had recently been increased

across the service by 160 hours per week to address the current high dependency levels of people supported. Staffing was now one nurse and four care staff throughout the day per unit. At night each unit was covered by a nurse and two care staff. He told us the need for a further staffing increase in one higher dependency unit would be considered as current bed vacancies were filled. The acting manager was also considering the introduction of nine hours per day of additional 'hostess' cover to assist with fluids promotion and mealtime support, which had been identified as another area of concern. To date this had been part of the responsibilities of the activities staff. We saw activities staff supported people at lunchtimes during the inspection. At the time of this inspection there were 130 hours nursing and 180 hours care staff vacancies. Shortfalls were covered by agency staff (around 300 hours per week). The impact on continuity of care was reduced by using regular agency staff wherever possible. A recruitment drive was ongoing and interviews were scheduled.

We asked a relative if they thought there were enough carers on duty to provide safe and effective care. One relative said, "I think they have enough time. They don't ever seem to be rushing". We asked staff the same question. One staff member told us, "Until the new manager came a few weeks ago, we were short staffed. There might only be two carers on the unit but now it's always four plus the nurse". Another staff member said, "It's much better than it used to be. I just didn't have time to spend with the residents before, just running from one to another giving basic care. Now we can give people the time they need". Our observations during our visit to the home showed that staff had time to spend with people in a meaningful way. Staff interactions with people were person centred rather than task oriented.

Recent inspections by the supplying pharmacist had identified instances of inappropriate medicines management and recording practice, not in accordance with nationally recognised guidance or the provider's own procedures. For example, there were instances of medicines administration or recording errors identified. Some issues were recurring in pharmacist reports. Similar issues were identified in a 'Clinical Governance Analysis' completed in December 2017, a 'Quality Improvement Review' carried out in February 2018 and the reports of visits by the provider's 'Clinical Support Team' in January and February 2018.

We found this was still the case on examining medicines administration records (MAR), during this inspection. We saw both recording omissions and possible administration omissions and a failure to maintain an accurate audit trail for medicines. The ongoing nature of these issues suggested failings of the in-house monitoring process reported to be in place and an absence of effective management action to date, to address these issues. One person was prescribed a medicine 'when required' (PRN). This was not identified on either the MAR sheet or the original packaging and had not been picked up when the medicines were checked in. This resulted in a potential risk of the medicine being given when it was not required. No evidence was available to show the medicines issues identified had been properly recorded or reported to management.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

Medicines audits in June and July 2018 also identified an ongoing absence of protocols describing the appropriate circumstances for administration of PRN medicines. We found this had now been addressed. PRN protocols were seen which also described the appropriate other steps to be taken before the medicine was administered. In one case, additional information describing the meaning of 'agitation' for the individual was needed, to ensure staff would not administer based on their own interpretation of this term. Where a person was given their medicine's covertly, this was appropriately addressed via an assessment of mental capacity and a best interest decision involving consultation with family, the GP and pharmacist.

The home was clean and free of any malodours during our visit. The provider ensured there were adequate supplies of personal protective equipment (PPE) for staff, such as aprons and gloves. There were individual infection control risk assessments in people's care plans. All hand basins were provided with hot and cold water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff had a good understanding of infection prevention and control.

Requires Improvement

Is the service effective?

Our findings

People told us the level of effectiveness of the service had improved recently. One person told us, "It was terrible, [before] [there were] too many agency staff, some could be rough, poor manual handling. Now staff are good. There is a good bunch here now." They were highly critical of some previous agency staff in particular. Another person said, "It's brilliant here now. It was alright [before] but it's a hundred times better now," The person put this down to the arrival of the new manager. They added that, "staff encourage some self-care."

Concerns had been raised by the local authority and a relative, about ineffective fluids intake management by staff. The acting manager told us improvements had been made, through some refreshers to staff knowledge and monitored via random audits of records. The service had previously tried to monitor fluids intake for everyone which placed an additional burden on staff time to maintain records. Now fluids monitoring was only in place where a level of risk had been identified. Initiatives were also being trialled to help improve fluids intake. For example, using coloured drinks as opposed to water, which had been shown to encourage consumption. A range of non-alcoholic 'cocktails' was also being promoted as well as milkshakes and fortified drinks where dietary intake was also a concern.

We examined a sample of fluid intake records and found there were gaps in recorded daily targets and calculation errors. There was a lack of adequate written records of action taken where shortfalls were noted and no reference to any resulting care plan changes to alert staff to these. This was despite the reported system of nightly audit of these records by the nurse on duty. The absence of significant analysis of fluid intake records or of recorded actions, suggested a lack of understanding of their purpose beyond basic statistical recording.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

The care plans contained up to date and relevant information about people's dietary needs. These included choking risk assessments, the use of food charts and, where necessary, referrals for specialist advice from dieticians and speech and language therapists.

Staff were available at mealtimes to assist people who required support to eat their meal. They sat down with people where assistance with eating was neeed. People gave mixed feedback about the meals. One person said, "The food is alright but it's the same old things." They added they had asked for more variety. Another person said of the food, "Some is alright, some isn't. You can ask for specials, if you put in for it." They told us they couldn't read the menu very well and left it until mealtimes to decide what to have.

The staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves.

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).

We asked staff about their understanding of the MCA and DoLS. Staff had undertaken recent training in this area. They could tell us the implications for the people they were supporting. The purpose of DoLS, which is part of the Mental Capacity Act (2005), is to ensure that someone, in this case living in a residential setting, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. Staff were clear on people's rights to make their own decisions whenever possible and for people with capacity to take risks and make potentially unwise decisions. Evidence of best interest meetings with relevant parties present and copies of Lasting Power of Attorney for Health and Welfare, where appropriate, were usually, but not always, present in care plans. For example, one person's file contained appropriate evidence of a best interest discussion with family, the GP and pharmacist about covert medicines. The record of DoLS applications suggested these decisions had mostly been made appropriately. We noted various DoLS applications were 'decision specific'. They clearly outlined why the person was being deprived of their liberty and how it was to be done in the least restrictive way. People's files mostly, but not always, contained evidence of mental capacity assessments carried out as part of the process. We noted this was completed during the process of care planning and reviewing. However, we found inconsistencies in some of the files we looked at. For example, we noted a DoLS had been sought for one person in August 2017, as they could not "perform activities of daily living due to a lack of capacity". The request stated the person had a diagnosis of dementia. However, their mental health and cognition plan of April 2018 stated they had no diagnosis of dementia. There was also a mental capacity assessment, undertaken in May 2018, which confirmed the person had mental capacity. Four people in another unit, assessed as lacking capacity, had bedrails in use but there were no DoLS or best interest records on file relating to this. Inconsistencies and gap in DoLS and best interest records were also identified internally during management bedrails audits in June 2018.

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

Staff sought the consent of people with capacity before providing support and sought the agreement by cooperation, of others. We looked at care plans with regard to issues of consent and capacity. One person's bed rails risk assessment in August 2018 stated, a family member had required that bedrails must be used. The person was reported as having capacity and there was no explanation in the care plan as to why the person themselves had not been involved in making that decision or signed a consent form for the use of bed rails. In other people's files family members had signed bedrails consent forms but there was no evidence on file confirming them having power of attorney giving them the right to consent.

These situations were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

People were happy with the healthcare support provided. One said, "My health is well looked after. If I'm ill they call the doctor." Another person told us, "They are good with health and I get my meds (medicines) on time." The effectiveness of some aspects of healthcare within the service had been raised as a concern by the local authority, particularly with respect to the effectiveness of pressure area care. The acting manager reported that the number of people with pressure damage or other wounds of concern had recently been reduced significantly. From twelve down to three, with only one being a pressure wound developed within

the service. Appropriate wound monitoring and care was being provided for this and other wounds with support and additional training from the tissue viability nurse. Wound management records included photos of healing progress.

We noted from our examination of care plans, that people were able to access a wide variety of core and specialist external services. For example, referrals had been made on behalf of people to agencies such as hospital consultants, dieticians and Primary Care Paramedics. Staff were evidently aware of people's health status and acted accordingly. All of the people living at the home were reviewed weekly by a visiting GP.

We did not speak with staff about their experiences of induction when first coming to work at the home as those we spoke with had worked at the home for several years. The records provided for induction/ Common Induction Standards/Care Certificate or In-house induction training combined showed 71% completion.

We asked staff about opportunities for training and development. One staff member said, "There's been lots of training lately. Some of it is on line [e-learning] and some by an in-house trainer". Another staff member told us, "I think the new manager wants us all to do a refresher on the basics. I think that's a good idea". We asked about training on offer for registered nurses. The staff we spoke with told us they were satisfied with the training provided. The acting manager confirmed that two days refreshers of all mandatory training was scheduled for staff the week following the inspection. According to the training figures provided, the level of compliance was already between 74 and 90 percent for the provider's mandatory courses, with the exception of basic life support training. The percentage of staff with up to date training in this area was 57%.

The acting manager said the provider target for one-to-one supervision was six per year. The percentage compliance with this according to the provider's records, was 74%. The acting manager said he had carried out some group supervisions to help ensure staff had opportunities for supervision, given current vacancy levels and the turnover of senior staff. We asked staff about the managerial support they received. One staff member said, "I get supervision from one of the nurses. It is a two-way process and I can say what I want". Another staff member told us, "The supervision is good. It's confidential and it's open and honest". Staff also received at least an annual development appraisal. The service was almost 93% compliant in this area.

Some work had been carried out to make the environment more suitable for people living with dementia but further development was needed and planned by the acting manager. The provider operated a development scheme called '10.60.06' regarding optimising provision for people with dementia, with reference to nationally recognised guidance. The provider's in-house dementia specialist team were in the process of completing a baseline audit of the dementia environment to identify the areas requiring further development and staff training. They had identified training, suitable activities and addressing agitation/distress as initial priorities. We asked for a copy of their report but this was not provided before the drafting of this report. Six staff had already received additional dementia training with more courses booked. The provider's stated the target was for all staff to complete level 1 dementia training. Other levels of dementia training were targeted at smaller numbers. The higher-level dementia training, was intended to then be cascaded to junior staff by the trained staff.

Amongst a range of plans as part of the provider's dementia initiatives, pain and depression assessment tools were to be introduced once staff training had been provided. Some staff had also already attended additional training on identifying and responding to distress reactions in people with dementia. Further enhancements of the mealtime experience were also planned.

Good

Is the service caring?

Our findings

People said staff were now more respectful and treated them with more kindness. One was especially pleased male staff were available as this was their preference, but understood the service could not guarantee male staff on every shift. In that situation, they were happy to be supported by known female staff.

We observed care and support given to people throughout the day. We found the care to be safe and appropriate, with adequate numbers of staff present. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. Staff checked people's wellbeing and greeted them by name and with politeness.

There was a high level of engagement between people and staff and we saw no incidents of infantilising or discourteous staff actions. Staff were responsive to people's needs and addressed them politely and in a timely way. It was evident staff knew people really well. For example, staff knew people's food preferences without referring to documentation. Those at risk, for example, those presenting with choking risks, were monitored closely but discreetly where necessary. Specific staff were assigned to take meals to people eating in their rooms and provide any necessary support. The provider was refreshing the dignity training to all staff.

We looked at people's care plans in order to ascertain how staff involved people and their families with their care as much as possible. Care plans and risk assessments were discussed and agreed with people or their representatives. Records of contact with family members were kept. We also found evidence of their formal involvement in people's care, in the form of six monthly reviews, to which both people and their representatives were invited. The acting manager also told us they had responded to people's preferences, where known, about having their bedroom door open or closed when using the room. People's other diverse needs were identified and addressed. Spiritual needs were addressed through visiting clergy.

We observed staff interacting with people throughout the day. Staff were respectful and kind to people. We saw numerous instances of genuine warmth between staff and people. On these occasions, staff took time to explain their actions in order to minimise people's anxiety. For example, staff treated people with dignity and respect whilst supporting them with transfers, talking them through the process. The same was true at mealtimes, where support and encouragement were offered in a relaxed and dignified way.

There was a calm and inclusive atmosphere in the home. The staff were knowledgeable about the people they were caring for and were able to explain to us their individual needs and requirements. It was evident staff saw people as individuals. One staff member told us, "We do get time to spend with the residents and get to know them now. We all do". We saw staff sat with people to provide company and interaction whilst completing some of their recording.

We asked staff if they thought the home was a caring place. One staff member told us, "Yes, I've worked here for years and I wouldn't stay if it wasn't caring. I think that's one of the strengths of this place". Issues relating

to inappropriate staff approach had been addressed. The acting manager had requested obscured glazing for office windows where they opened onto corridors, to improve confidentiality regarding information written on the white-boards within. People's written records were stored confidentially.

Requires Improvement

Is the service responsive?

Our findings

People felt the service responded to their needs. One person said, "If I wasn't happy I'd tell you." A relative gave us very positive feedback about the responsiveness of one of the nurses who had stayed on long after their shift ended to ensure something was properly addressed. Another relative had written to the acting manager giving positive feedback about the care provided by a nurse, highlighting the difference in the unit since the establishment of specific teams.

We examined people's care and daily records. They were legible, up to date and securely stored. People's choices and preferences were documented. We noted people's histories were detailed in some files, but less so in others, however it was possible to 'see the person' in care plans. The staff we spoke with were knowledgeable about the people they were caring for. However, the daily records we looked at were rather clinical and task oriented. Limited insight into people's daily lives could be obtained by reading them. These records almost exclusively described care task completion, such as positional change and food and fluid intake. Little information was available about people's emotional and social needs, engagement or wellbeing.

Care plans and risk assessments contained mostly relevant, up to date information, except for the omissions and contradictions already noted. For example, one person was diabetic. There was evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to maintain health. Their blood glucose levels were taken and recorded appropriately. There was guidance in the care plan to aid staff in the management of possible emergencies relating to diabetes. The staff we spoke with understood their responsibilities in this area.

Another person living with dementia occasionally required support with verbal and physical behaviours. Staff recorded incidents related to this in behavioural charts in order to identify potential triggers. This information fed into a detailed behavioural care plan which informed staff how the behaviours manifested themselves. There was a flow chart describing the actions staff should take in order to keep the person, other people and staff safe.

A third person was bedbound and as such was at high risk of developing pressure sores. We noted there were up to date and relevant risk assessments in place, particularly around contributing factors such as nutrition and mobility. The person was cared for on an air mattress, which was calibrated to their weight and regularly checked. There were body maps in place. The staff we spoke with were knowledgeable about this person and the care they received. The same person was subject to fluid intake monitoring as poor fluid intake represented a significant risk factor. We noted their fluid intake was monitored closely and fluids encouraged.

We spoke with a visiting health professional, who attended the home frequently, about the care provided. They told us staff referred to them appropriately and that they knew people's needs well. However, they did state that, on occasion, staff would bring issues to them that could have been resolved earlier by staff themselves, indicating a lack of confidence. We also noted from care plans that staff followed any advice or

guidance given by visiting professionals.

People told us the activities provided did not always particularly interest them or meet their needs. One person said they were happy they could have the drink they liked daily and was taken out for short walks daily. They added, "I don't do the activities. I don't like them, they don't offer anything for me." They were aware of the activities posted on the notice board and of the coffee mornings. Another person told us, "I join in with some [activities], but not others." They went out three days per week to a day centre for activities and enjoyed sitting in a communal area chatting to passing staff or sitting in the garden. We saw them enjoying the fresh air at times during the inspection. A visiting relative seeking a possible home for a family member had complained to CQC about potentially inappropriate activities which did not meet people's needs.

The acting manager acknowledged there was room for improvement in the range and suitability of the activities and entertainment provided. The activities team was being increased by one staff, to three co-ordinators to help provide a more individualised activities service. We saw staff took opportunities when they could, to speak to people or sit with them. Staff also took part in and led some activities at times. The planned increases in care staffing would provide additional opportunities for this. Activities training for key staff was planned in the next few months as well.

The complaints procedure was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. The staff were clear about their responsibilities in the management of complaints. However, some of the records of complaints follow-up were not clearly written or were incomplete. It appeared issues had been addressed, but the records did not always demonstrate a thorough process had been followed. A complaint referred to the provider for investigation by the Care Quality Commission (CQC) also initially elicited an inadequate response from a senior manager which was later amended to provide additional information. Overall, the record of complaints in the service was incomplete and showed a poor standard of recording. The acting manager agreed to ensure proper records were maintained, going forward.

The acting manager had addressed a previous concern about a lack of timely communication with families. Where appropriate and wanted, staff were now proactively contacting family to update them regularly about people's wellbeing. This was in addition to the scheduled three-monthly relative's meetings.

The service was non-compliant with the Accessible Information Standard, which is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information. Limited documents had yet been made available to meet specific needs. For example, one person had told us they could not really understand the menu. No easy-read or pictorial versions of documents such as the complaints procedure were available to help people understand their rights. The acting manager was unable to confirm whether an audio version of the complaints procedure was available to people.

Some technology was in use in the service to benefit people. For example, falls mats next to beds which alerted staff should a person fall from their bed. The acting manager was proposing to obtain infra-red movement monitoring devices where there were concerns about falls risks. These would be used to help keep people safe by alerting staff when someone who was at risk of falls got up at night or when they were in their room alone during the daytime. The acting manager also planned to explore the potential benefits of personal programmable wireless headphones for people nursed in bed, to enable them to listen to their preferred music or radio.

Recommendation:

The provider should refer to the guidance available regarding the Accessible Information Standard and address their current non-compliance as appropriate.

Requires Improvement

Is the service well-led?

Our findings

The service is required to have a registered manager. 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 service has had seven registered managers since its first registration in 2011.

The most recent registered manager left the service in early August 2018. She was replaced in the interim by an experienced registered manager from another of the provider's services. Since the home had neither a clinical lead nor a deputy manager in post the acting manager was being supported by a clinical lead from another service. Additional support was being provided by members of senior management and in-house specialist teams including the dementia team and clinical support team, pending recruitment of permanent staff to these posts. The acting manager saw his role as taking the service back to the basics of effective care following a period of increased concern about the quality and safety of care.

People and staff gave us positive feedback about their impressions of the acting manager, emphasising the significant improvements they had noted since he took up the position in early August 2018. One person said of the acting manager, "He is great. He has made changes. There are less agency staff. He comes around daily and speaks to us." Another person commented, "The new manager has taken on some new staff. He talks to you a lot more than the previous manager. He always says, good morning. He helped me change my bedroom around."

We asked staff if they thought the home was well-led. One staff member told us, "I really do, especially since the new manager came. We don't have a deputy yet but things have definitely improved". Another staff member said, "The home had had a lot of managers over the years. I don't think that has helped but hopefully we are on the right track now". A third staff member told us, "I think the staff have learned to just get on with it as managers have come and gone. This new one has made a difference though. They listen as well as talk".

The acting manager had re-established daily clinical meetings and had met with relatives and staff to introduce himself and explain his role. Interviews for key management posts as well as nurses and care staff had been arranged, some of which took place during the inspection. One team leader had also been promoted to improve the management structure. The acting manager had addressed some complaints made in the period immediately before his arrival. He described a range of audit processes he was using to become familiar with the service quickly, including daily walk-arounds and attendance at most daily clinical meetings. He felt the current level of people's dependency needs was too high and may have contributed to some of the issues which had arisen as well as to reduced staff morale. He planned to try and balance dependency levels more proactively, particularly while staffing shortfalls were addressed. He felt staff had not been given sufficient responsibility or encouraged to take decisions within their remit. He had already introduced core staff teams for each unit, in consultation with staff, to promote consistency and continuity of care. A 'resident's ambassador', (an ex-relative), took part in recent staff interviews. The acting manager

proposed to identify a current resident to also take on this role to further promote people's representation in the recruitment process.

From the rising level of concerns which had arisen over the 12 months prior to this inspection it was clear the provider's audit and governance systems had either not effectively identified or rigorously addressed a range of issues including those relating to people's safety and wellbeing. For example, there had been a large number of safeguarding incidents in the previous 12 months, some involving poor care or moving and handling practice. Each appeared to have been followed up and treated in isolation, with insufficient overview. A range of medicines management issues had been identified in successive pharmacy inspections, and noted in clinical support team visits in January and February 2018 and a regional director's monthly quality visit report in January 2018. Some of these issues were still evident at the time of this inspection despite regular clinical governance meetings throughout the previous 12 months.

Management monitoring reports had identified issues the previous registered manager had said were addressed, yet they remained of concern. It was not clear what if any action was taken at the time to address this. "Observation of Practice" visit report forms in October and December 2017, referred to staff shortages, poor manual handling practice and gaps in recording. Complaints records although reportedly monitored, remained poor and incomplete at the time of this inspection. The quality improvement review dated February 2018 identified a range of issues including incomplete care and other records including medicines records, food and fluids records, moving and handling issues, training gaps, a lack of robust knowledge of the provider's values amongst staff, food and environmental issues. Many similar issues were also identified in records audits completed in January and February 2018. Despite also being raised recently as one of the concerns of the local authority, we found fluids monitoring systems still contained errors, gaps and insufficient information about actions taken. Residents meetings had previously identified questions about staffing levels and the level of activities in April 2018. It was not possible to identify whether any action had been taken at the time, in response.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended).

It was evident the acting manager was beginning to address the priority issues in the short time he had been in post and he was in the process of prioritising his actions, partly guided by the action plan provided by the local authority. Progress will be monitored by the CQC and by the local authority through completion of their action plan.

The provider carried out a survey of the views of people and their families in 2017/18. The overview results showed improved levels of satisfaction with the service over the previous annual survey. For example, people's overall satisfaction with the standard of the home had reportedly risen from 89% to 100%, based on 17 responses. Family and friend's satisfaction had risen from 81% in 2016/17 to 92%, based on 24 responses. In some key areas reflected in this report, the service had, however, scored lower. For example, asked if staff have time to talk, satisfaction levels were 88% (people) and (61%) family and friends. On hobbies and activities, 88% of people and 65% of family and friends were satisfied. There was no action plan attached to the survey so it wasn't clear what the provider planned to do in response to the survey.

The acting manager held a resident's/relative's meeting on 15 August 2018 and a staff meeting on 30 August 2018 to introduce himself and outline some of the changes to be made and the actions being taken to address concerns about the service.

The registered manager/provider is required to notify the Care Quality Commission (CQC), of the outcome of

all Deprivation of Liberty Safeguards applications made. These required notifications to the CQC had been made very inconsistently. The service's records showed around twenty DoLS application responses received from the local authority in the previous 12 months. However, only four had been reported, as required, to the CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Under Regulation 20 of the "Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended)," 'Duty of Candour', the provider is required to make contact with a person or their representative where a notifiable safety incident has occurred. They are required to describe the circumstances of the incident and to offer an apology in writing.

It was not clear from the 'Duty of Candour' records completed by the previous registered manager that she had fully understood the requirements under 'Duty of Candour'. Records hardly ever referred to contact having been made with the person or their family or of providing an apology. The acting manager was able to show he understood the expectations under this legislation and undertook to ensure the regulation was followed going forward.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure that the outcome of all DoLS applications was notified to the CQC as required. Regulation 18(4)(B).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's rights may not always be protected. It was not clear that DoLS had always been applied for appropriately or where necessary. Best interest discussions may not always have taken place where appropriate or records thereof may not always have been made. Regulation 9(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights may not always be protected. Their consent may not always have been sought to aspects of their care; or consent may have been given on their behalf, without legal authority. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Treatment of disease, disorder or injury	People who used the service were not protected because the service had not ensured…the proper and safe management of medicines. Regulation 12(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
Treatment of disease, disorder or injury	People who used the service were not protected because the service was failing to ensure effectively that it was meeting people's hydration needs. Regulation 14(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People may not always have been protected from harm because the provider had failed to exercise effective governance over the service. Regulation 17(1).