Gateway Housing Association Limited

Peter Shore Court

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected this service on 28 and 30 July 2015 and 4 August 2015. The inspection was unannounced on the first day and, although the service knew we would be returning soon, they did not know when.

Gateway Housing Association became the provider of this service in July 2014, this was the first inspection under this provider.

Peter Shore Court provides care home accommodation for up to 41 older people, many of whom are living with dementia. If people require nursing care this is provided by the local community nursing service as it would be for anyone living in their own home. If anyone requires full-time nursing care they have to move to a service which provides this. Most people remain in the service long term, a few visit for short breaks / respite care. The care home is purpose built and each person who uses the service has a light and spacious bedroom with en-suite facilities.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008

Summary of findings

and associated Regulations about how the service is run. A new manager had been appointed and was serving her notice with her current employer; an agency manager was covering in the interim. She had only been in post for a week at the time of inspection.

The service was in a state of transition. We found the provider had well-thought through plans for the service which put people who used it at the centre of everything they did. They had good underpinning policies, procedures and processes in place, but the high turnover of staff and managers prevented these from becoming fully embedded in daily working practices. In addition, we found that there were insufficient care workers at busy times.

Inconsistent practice was observed throughout the inspection, where it was good it was very good, but there were many examples of poor practice. Whilst there were some exceptionally caring members of staff (both employed by the provider and from agencies), others failed to engage with the people they were meant to support, so people who used the service did not receive consistently good care. We found most staff could describe what good care looked like, but we observed too many situations where staff did not apply the theory to their practice. Staff did not get regular opportunities to reflect on how they delivered care or sufficient support to organise tasks in order to ensure individuals' needs were fully met, particularly in relation to eating and drinking.

Staff lacked awareness of the provider's fire evacuation plans on day one of the inspection. We raised this with the provider and, by day two, this issue had been resolved and there was a process in place to ensure every member of staff received a reminder.

The provider was very honest about the challenges involved in delivering good quality care and we saw evidence of issues being addressed as soon as they became known. Some areas, such as staff recruitment, were complex and took longer to fix than anticipated. We found lots of improvements had taken place in relation to the premises, such as new carpets. Two new boilers had been installed to ensure a continuous supply of hot water and heating.

Most of the issues we identified within the service could be traced back to inconsistencies in local leadership and staffing. We found breaches in regulations in relation to staffing, fire safety and person centred care. You can see what action we have told the provider to take about this at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The service had insufficient staff to meet individuals' assessed needs and there was an over-reliance on agency staff which resulted in inconsistency of care and support for people who used the service.

Most staff were not aware of fire evacuation procedures when we arrived, but the provider took steps to remind them of these before we returned.

There were systems in place to maintain a clean environment, although standards slipped when domestic staff left for the day.

Medicines were administered as prescribed.

The provider had taken steps to improve the premises and more work was planned.

Is the service effective?

Requires improvement

Aspects of the service were not effective. Staff benefited from good quality training, but needed more guidance to apply their knowledge in the workplace; staff supervision was not provided consistently.

Care staff understood the broad principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS), but did not always know who was subject to DoLS and the implications for that person's care.

Support to eat and drink and monitoring of people's intake was inconsistent at times. There were close links with a local GP practice.

The provider had improved the fabric of the building and the fixtures and fittings within it. More improvements were planned, including a new 'carer call' system.

Is the service caring?

Requires improvement

The service was not consistently caring. Whilst some staff demonstrated an exceptionally caring approach, other staff did not try to engage with people who used the service.

Staff were aware of the need to protect people's privacy, dignity and confidentiality.

Is the service responsive?

Requires improvement

The service was not always responsive. Whilst staff were fully aware of the need to offer people choices, this was not observed to form part of some staff members' routine.

Care plans offered staff guidance about how to meet people's needs, but there were some contradictions within them and some gaps. This was mainly because staff did not systematically transfer information from other records.

Summary of findings

Group activities were available, but staff had little time to offer any activities outside these sessions.

The provider had a system in place to log and track concerns and complaints, but no complaints had been logged recently.

Is the service well-led?

Requires improvement 

The service was not well-led at all levels. The provider had not managed to retain a manager and, although they had ensured the post was covered at all times, the service had not benefitted from strong consistent local leadership and the associated attention to detail.

The senior management team was able to provide us with extensive evidence of the steps they had taken and intended to take to improve the quality of care. They had made significant progress in some areas, such as improvements to the premises, but slower progress in relation to staffing. We found them to be open, honest and creative. Appropriate policies, procedures and processes were in place to underpin service delivery.

Peter Shore 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 provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over three days on 28 and 30 July 2015 and 4 August 2015. It was unannounced on the first day and, although the provider knew we would return, they did not know exactly when. On the second day we arrived at 6.45am when night staff were still on duty. The third day of the inspection took place at the provider's head office where electronic records were examined.

The inspection team comprised five inspectors, one was in attendance on all three days of the inspection and the others participated on one or two days. An expert by experience joined the inspection team for one day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a service for older people.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 also looked at other information we held on the service. We read the most recent report and associated documents produced by the local authority's monitoring officer and the 'Enter and View' report produced by Healthwatch – Tower Hamlets.

During the inspection we spoke with 12 people who used the service and two relatives. The majority of people who used the service were only able to tell us their views on a small range of subjects, but we observed their interactions with staff and others in the communal areas of the service. We spoke with 17 staff members (both permanent and agency), including three based at the provider's head office.

We observed the morning handover and the medicines round on both floors. We reviewed four staff recruitment files, all staff supervision records for the last year, the complaints log, the fire log book, all current medicines administration records on the ground floor and a range of management records, such as those relating to health and safety, as well as quality audits.

Inadequate

Is the service safe?

Our findings

A person who used the service told us, "[The service] has gone down and down because there are not enough staff on." On one occasion after lunch was served promptly, a person who used the service said, "Things are different today because [the inspection team is] here. There were three staff serving lunch which is never the case." A member of staff said, "There are so many agency workers on a daily basis, which means there is no consistency. It is giving us such a hard time." Another member of staff said, "We need an extra care worker on shift."

We found that staffing levels were inadequate to meet the needs of the people who used the service. During breakfast on the second day of inspection, the inspection team had to ask for an additional staff member to be brought in as they felt people who used the service were unsafe. An agency member of staff had failed to turn up. The provider responded promptly and appropriately when the inspectors brought this to their attention.

We looked at people's dependency level scores and by the provider's own calculations they required a further 28 care worker hours per week. We observed most people needed one to one support to engage with tasks or to attend to their personal hygiene. On the first floor during the day, three care workers and a team leader were scheduled to work with up to 22 people who used the service. On the ground floor two care workers and a team leader were allocated to 19 people who used the service. The team leaders had little time to get involved in delivering direct care as they had to administer medicines, deal with the arrangements for people's medical appointments, provide supervision sessions for staff and carry out many other duties. A team leader complained. "Our time with people is taken away significantly because the daily documentation is lengthy and complex, we spend more time on this than we do on caring for people."

At night one team leader led a team of three care workers who covered both floors, yet many people had disturbed sleeping patterns and were up and about throughout the night.

A team leader told us, "There's always at least one permanent member of staff on the floor. This doesn't seem like much but it feels stable to me, we tend to see the same agency staff repeatedly, which helps give consistent care to people", but another team leader said, "We don't tend to have the same [agency care workers] coming back." Staff members told us they were resigned to working short-handed if someone was off sick. This was due to the inability of the agency to supply staff at short notice. The provider had recently contracted with a second agency in an effort to improve matters and was looking at creating its own bank of staff. At the time of the inspection, agency care workers and permanent staff working additional hours were used to fill any gaps in the staff rota. Senior management told us they tried to ensure each medium to long term vacancy was filled by a single agency worker to maintain continuity. The rota showed that, whilst this was the intention, it was not happening over the summer period; there had been a high turnover of agency staff.

The provider's own records indicated there had been an increasing number of falls within the home. One senior manager told us staff were now recording falls that did not result in an injury; a staff member suggested the variation was closely linked to changes of manager, each of whom had a slightly different threshold for falls reporting. Whilst both factors may have played a part in the change in the number of falls, we also observed people who used the service being left unsupervised in communal areas for up to 15 minutes at a time due to staff shortages and for longer when they were in their own bedrooms.

The deployment of staff was hindered within the building, according to several members of staff we spoke with, because external phone calls could only be picked up downstairs. This resulted in more experienced staff being allocated to the ground floor as they were most equipped to deal with any queries when the administrator was not on site, as well as any visitors. Staff time with people was also reduced because they had to spend time searching for things; either because they were not stored where they expected them to be or because supplies had not been topped up from central stores. Many of the issues we identified were more pronounced on the first floor.

Minutes from the relatives' forum showed family members were concerned there were insufficient staff to escort people to medical or other appointments. A senior manager told them and us that the service was not funded to a level which made this possible. The provider informed us that if alternative arrangements could not be made, then people were always accompanied by a staff member.

Inadequate

Is the service safe?

These issues amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to outline how they would identify and respond to a safeguarding concern. A care worker told us, "I especially check for bruises when I do personal care." Most staff were aware of their responsibility to raise concerns which impacted on the care of people who used the service. However, whilst one team leader was well-informed and knew about the provider's dedicated whistleblowing phone number, some staff were vague about the provider's whistleblowing arrangements. Another team leader said, "I don't know what the whistleblowing policy is, I've never seen it."

On day one of our inspection we became concerned about fire safety. Whilst appropriate policies and procedures were in place and fire safety equipment was available, care workers, with one exception, were confused about their responsibilities in the event of a fire, for example, one care worker told us they would ring down to the office to find out what to do if the alarm went off. Another said they would look at a person's moving and handling risk assessment before moving them away from a fire. A team leader said, "I think the rendezvous point might be out the back, I saw a sign around there." We found it was, in fact, in front in the garden square.

We looked at the fire log book and found that, whilst one section, was completed as required, two other important sections were not. The provider's policy, which was detailed in the log book, required staff to carry out a weekly check to test call points systematically. There were 10 call points, but only three had been tested in the last year by staff, although the others had been tested by an external company during maintenance and servicing. In addition, the section detailing fire drills was blank. We were told a fire drill was held the day before our inspection, but we did not see any record of this. The provider required staff to note the response to the fire bell and any learning points, but there was no evidence this had happened.

A fire risk assessment dated 15 September 2014 noted a lack of staff fire awareness. We saw the provider had sought to address this through training, but there were few staff on duty who had been around long enough to have benefitted from this. Having raised our concerns about fire safety on day one of the inspection, by day two we found the provider had summarised their evacuation procedure and required all staff, including agency staff, to read it before they started on shift. Consequently, the staff we spoke with on day two of the inspection were much better informed about how they should respond to the fire alarm.

One of the fire exits from a courtyard area was blocked by a large wheelie bin. When we pointed this out it was swiftly moved.

Although the provider took prompt action to address the shortfalls we identified, this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were certificates and other documentation in place to show the premises had received appropriate safety checks, for example there was a gas safety certificate and evidence the fire extinguishers had been serviced. There was also evidence the provider was upgrading the premises to reduce the risk of equipment failure, for example, during the inspection a stairlift was being installed in case the lift broke down and in anticipation of the lift being out of commission whilst it was replaced. The single boiler had been replaced by two boilers to ensure the continuous provision of hot water and heating. Staff reported a prompt response when repairs or maintenance were requested and this was confirmed by records. A member of domestic staff told us, "If we can justify why we need new equipment or furniture, there is no problem getting it."

The new housekeeper had systems in place to maintain a good standard of cleanliness, although we found the hairdressing salon had been overlooked. New carpets had just been laid in many areas and an air purifying system had been installed in some rooms. The home smelled clean and fresh throughout, but we found essential cleaning and re-stocking was not always taking place promptly when domestic staff were not in the building. For instance, we saw one communal toilet had a seat soiled with faeces for two hours and two toilets had no toilet paper in them. Staff on duty could not tell us who was responsible for checking these in the night or during early mornings.

There were appropriate systems in place within the laundry to promote good infection control and to reduce the risk of clothes going missing. An external firm attended the day before the inspection to carry out a deep clean of the main kitchen. The service had received five stars (the top score) for food safety.

Inadequate

Is the service safe?

We found that rooms used for storage were not always kept locked. Two bathrooms on the first floor were used for storage. Each had a sign on the door that instructed staff to keep them locked at all times. On the second day of our inspection we found that both doors were open for several hours.

The provider had appropriate emergency plans in place, including IT recovery systems. The service benefited from its proximity to the provider's other home so there was a warm place to evacuate to, if required. An emergency on-call system was operated by managers and when we tested this we got an immediate access to the person on duty.

We saw the provider had taken steps to obtain evidence of the suitability of all staff to work within the service. This included staff who had transferred from the previous provider and for whom the current provider, initially, had few records. It was difficult to track everything within the files kept on site, which were incomplete in some cases. In particular in relation to checks on unexplained gaps in employment history. However, we saw the provider's human resources team held more complete records than those held within the service itself, such as information about criminal records checks. This confirmed the provider was following their own safer recruitment policy for new staff.

There was evidence the provider had followed up under-performance and used its disciplinary procedures when additional support and training did not enable the staff member to carry out their role effectively.

There had been some errors when administering medicines in the past. This had been identified by the provider and also reported to one of the agencies which provided staff; they worked together to tighten up procedures to reduce the risk of this occurring again. At the time of inspection we found there were appropriate arrangements for receiving, administering and disposing of medicines. Staff were following the correct procedures. One person who used the service was able to confirm, "I always get my painkillers when I need them." We observed checks being made on controlled drugs at the morning handover. There was also evidence of team leaders making daily stock checks of other medicines, including those supplied as liquids and thickening shakes.

On the first day of our inspection we found the first floor medicines cupboard was too warm; some medicines will deteriorate if kept over 25 degrees Centigrade. On occasion, during the past year it had been recorded at 38 degrees. The provider had identified this, but the remedial action, keeping the door and window open, was inappropriate, even though the medicines were locked in cabinets. We pointed this out and when we returned for the second day of inspection we found the medicines had been relocated.

Requires improvement

Is the service effective?

Our findings

A member of agency staff commented, "The permanent carers are very well trained – they really know people's preferences and personalities." This was confirmed by a permanent care worker who said, "The training is very good, especially for looking after people with dementia and for understanding safeguarding." When we discussed lunchtime arrangements with one person who used the service, they said, "We're always sat here too early but it's because [staff members] need to help the others who can't move very well. But I don't know why they don't switch the lights on, it's so dark!"

We looked at the training plan and tracker for the home. We found that a rolling programme of training was in place to ensure that staff maintained competency in mandatory training, such as safeguarding, moving and handling and nutrition. All permanently employed care workers were up to date with their mandatory training and many had attended other relevant short courses. On the second day of inspection three staff members were attending a course on working with people with learning disabilities to help them to better meet the needs of a few people who used the service. Staff commented favourably on the quality of the training, which was provided face to face. The provider told us they intended to implement the new Care Certificate in the future.

The provider had entered into contracts with two employment agencies to supply staff. Senior managers told us the agencies were required to supply care workers with a minimum of national vocation qualification (NVQ) level 2 in health and social care. From speaking with staff we found inductions for agency staff tended to be informal. One agency team leader told us they had shadowed another team leader. An agency care worker told us that they hadn't had a formal induction but they had been introduced to each person individually.

The provider's own audit indicated that 95 per cent of care staff received monthly supervision in the first three months of this financial year (April to June inclusive), but we could not find evidence to confirm this. Senior managers investigated and found only three care staff (out of 21) had received supervision at the intervals required by their policy. Five care staff had not received any supervision in this period.

Most people who used the service had been referred to their local authority for an assessment of capacity. The majority of them had been assessed to lack capacity to make some decisions for themselves and there were deprivation of liberty safeguards (DoLS) in place.

Staff we spoke with had a broad understanding of the Mental Capacity Act 2005 and DoLS, but some of them had little awareness about how they needed to adjust their practice for each individual. One team leader was able to give us an account of how they worked with an individual who had to capacity to, sometimes, make unwise choices. It was clear the team leader had given careful consideration to the issue and their approach was sensitive and respectful; they ensured the person had correct information and access to support so they could make a better choice. However, another team leader was observed to amend the same person's care plan without discussing it with the person concerned. The person later complained to the inspector about the lack of consultation.

Much of the information about applications for DoLS was held centrally in the manager's office. There was less information about the outcomes of those applications. Care plans did not routinely guide staff in the area of mental capacity or the DoLS which were in place for each individual. For example, although the administrator had information about who had authority to make decisions on behalf of people who used the service in relation to financial matters, care staff did not know if anyone had authority to make welfare decisions.

When we looked at people's care files we saw each person had a consent form in their care plan which should have indicated who had given consent for their care. One person's form was not completed and had a note attached stating, "Doesn't have capacity". It was not clear who had written this, when it had been decided or on what basis.

Training had been provided, but staff needed assistance to put their learning into practice. We witnessed an instance of poor practice which was temporarily restricting one person's liberty. A person who used the service called an inspector into their bedroom, as they had been stranded because both their walking frame and their call bell had been placed out of reach during cleaning.

People were checked on admission for signs of malnutrition using a recognised screening tool. We saw people's weights were monitored monthly and staff told us

people were referred to a dietician by their GP if any problems were flagged up. However, we found inconsistencies in the routine recording of peoples' weight and their fluid intake. For example, one person had been assessed to be at risk of weight loss, but their weight had not been recorded in the six months prior to our inspection. Another person was at risk of malnutrition and had been identified as having a low appetite and should have received a weekly check of their weight. This had not taken place since January 2015.

Food looked well-prepared and nutritious. One person said it was often cold by the time they received it; other comments referred to the food as "good" and "OK". Portion sizes were generous, but a few people found this a bit overwhelming and told us they preferred smaller amounts. In their hurry to get everyone served, most staff members placed lunch in front of people without discussing it with them.

One person waited 55 minutes in the dining room for their toast during the breakfast service. We asked a care worker about this. They told us, "We're going as fast as we can but there aren't enough of us to make the toast and serve it quickly; some people do have to wait." People who used the service required more assistance with hand hygiene before meals. We observed some people were eating with soiled hands.

A person who used the service said the inspection had influenced staff behaviour at lunch time, "I saw a care worker actually take the time to help someone eat [today] – normally they just give a spoonful as they walk past a person." We observed a member of staff who initially stood behind a person to assist them, before sitting down to their side. They did not speak with the person at all.

One person was unhappy about their plate of mince, because they were a vegetarian. A member of kitchen staff confirmed, when we enquired, that it was Quorn (vegetarian) mince, but this had not been made clear to the person. Condiments were not placed on the dining tables, a staff member told us this was because, "It is a safety hazard – they can ask if they want salt and pepper." We noted some people had lost the ability to make requests.

Snacks were always available, we saw early risers had been provided with sandwiches and a hot drink to keep them going until breakfast. The provider had conducted a survey of people's preferred foods and a menu plan had been devised to reflect them. However, we found the menu plan was not always followed. For example, cooked breakfasts were no longer offered, although they remained on the menu which was placed on each table. A care worker said, "I don't know why the menu lists a cooked breakfast, there's no-one here to make that." When we pointed this out to a senior manager they quickly reinstated the cooked breakfast.

Many people who used the service could not recall when they last ate or drank and found it hard to recognise when they were hungry or thirsty. There was no system in place to ensure everyone, including those who moved around independently, received or consumed drinks or snacks at regular intervals. We could not be confident individuals' needs in this area were not sometimes overlooked, given the shortage of staff.

These issues indicated that there were not effective systems in place to ensure that people's individual needs were met which amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had arranged for the local GP practice, with whom most people were registered, to attend the service each week for four non-urgent appointments. Urgent GP appointments were dealt with in the usual way, as they would be for a person in their own home. There was evidence of liaison with some other healthcare professionals on an 'as required' basis, for example mental health services. A team leader told us there were sometimes delays in getting advice or treatment; they put this down to pressure on local health services.

One person was able to get out of bed with the aid of a hoist but refused to do so because they were afraid of being moved in this way. We saw that contact had been made by the person's physiotherapist, who was concerned that the person was not regularly encouraged to get out of bed. There was no recorded follow-up from staff with regard to this contact and during our inspection the person remained in bed.

Although we saw people had access to a visiting optician, very few people were supported to wear their glasses. It impacted on their ability to read the menu, watch the television and other activities. One person's care plan

reminded staff to ensure their glasses were clean and polished for them to watch television. We saw they were not wearing glasses and none of the staff we asked were able to tell us if they should be.

People who used the service benefited from spacious bedrooms with an en-suite toilet, wash basin and shower. There was some evidence of dementia-friendly design, such as red toilet seats in some en-suites to help people pick out the lavatory and pictorial signs. The provider informed us that they intended to enhance this when people's bedrooms were upgraded.

A replacement carer call system was planned. The present system was fixed to the wall, but the new system would operate using wristbands or pendants, making it much more suitable for people who walked around unescorted. In the meantime we asked the provider to see if there was anything they could do to make the current system more accessible by further use of cords. These were attached to the wall units in some rooms, but not in others. The call points in some of the communal areas were not always sited where people could reach them easily, which was a concern when people were being left unsupervised for periods.

Most bedrooms contained a pull-cord for the light switch as well as a wall switch. In some bedrooms the beds were not located in such a way that people could reach the light pull. This increased the risk of falls.

Requires improvement

Is the service caring?

Our findings

A person who used the service told us, "[Staff] couldn't get any better – very kind and patient." Another person told us, "Staff always knock before they come into my room, they are very polite." A staff member said, "I've only been here a few weeks and I'm starting to get fond of the residents. It grew naturally because I see them daily and really get to know their ways." A team leader told us staff had to "let people do their best" and then step in to fill any gaps. This demonstrated they were aware of the need for people to maintain their independence, but also of their need for support in some areas.

We observed some exceptionally caring staff at work; some were permanent staff, others were agency staff. One member of staff was particularly popular with people who used the service. One person told us it was because they "smiled and smiled". We saw this staff member gently stroking people's hands to reassure them when they were upset or had difficulty communicating.

We asked some care staff how they communicated with people living with dementia; one member of staff told us, "By working closely with people you get to know their body language. Even if they do not speak I speak all the time and [offer them] choices." Another staff member told us they made sure people were happy for them to carry out a task, "By asking the question in many different ways and taking note of body language – you don't do the thinking for them."

During our lunch observation on the first floor, we saw an agency care worker had a good understanding of how to make people relaxed and happy. For example, one person liked to bring their doll with them to lunch and they were clearly delighted when the care worker made space for the doll beside them on the table and gave it a napkin as well.

In some cases care workers were skilled at de-escalation techniques and had a good understanding of how to support people with complex behaviour needs. For example, a person who was distressed and becoming very agitated was distracted by a team leader who was kind and gentle with the person, offering them a cup of tea and a quiet place to talk.

Unfortunately we also saw care workers who carried out their duties in silence with no attempt to engage with people who used the service. For instance we saw one care worker serve hot meals without speaking to the people they were serving. Although we found some good examples of listening to people who used the service and involving them in their care, this area of work was under developed. We saw it could be difficult to communicate with some people, but some staff carried out tasks, such as escorting them to another room, without attempting to explain what they were doing or asking people if they were happy about it. No communication aids were in use. The shortage of staff made it difficult for care workers to take time to talk to people, but we noticed some of them managed to fit this in, often whilst they were doing something else at the same time.

People who used the service were supported to maintain links with family and friends. One person said, "When a lot of my family visit [at once], we are shown into the activities room and we can make tea and coffee there."

People's culture and religion was respected. We observed staff exchanging culturally specific greetings with two people and some religious services were held for those who wished to attend. There was evidence of menu adjustments being made in order to meet people's dietary requirements. Families often brought food into the service to share with their relatives.

Staff were mindful of confidentiality. For example the administrator told us they never disclosed to other staff how much money people who used the service had, as this was "only the business of the person and their representative".

Most staff tried to protect people's privacy and dignity. We observed one team leader very tactfully and discreetly move a colleague who was about to discuss people's needs in a location where they could be overheard. At times there were insufficient staff around to help maintain people's dignity, for example, as they emerged from a toilet.

Requires improvement

Is the service responsive?

Our findings

We found staff were inconsistent about offering choices. We observed some had built this into their practice and routinely asked people what they wanted, but others had not. For example, one staff member put lunch in front of a person without any explanation. We asked them how the choice had been made and they told us the person had made their choice earlier in the day, with no acknowledgement that the person may have forgotten. Following this conversation the staff member gave others a choice of food by holding up two different plated meals in front of them, without explaining what either was.

Staff did not always pay enough attention to people's wishes in relation to the environment. Inspectors were approached several times during the inspection by people who complained rooms were too dark or too stuffy. We had also been contacted prior to the inspection on behalf of someone who had been left in a draught.

Care plans included information for staff on how to provide care for people. For instance, one person had been identified as at risk of low skin integrity and staff were instructed to manage this by conducting checks on them three times each day, encouraging fluids and by providing a high protein diet. This person also needed additional checks from staff after a stay in hospital. We saw from their care plan that staff had been consistent in performing the checks and recording the results of these.

Each person had their personal preferences recorded for how they wanted to be cared for during the night. For instance, one person liked to keep their bathroom light on. Other people had a particular bedtime routine that included their favourite drink before bed. We saw each person had an hourly check during the night by a member of staff and that this had been recorded.

Although care plans were clearly written and offered guidance to care staff, there were some gaps and inconsistencies. The outcome of safeguarding investigations and the implications for that person's care were not routinely transferred to the relevant individual's care plan, nor was any learning or actions from incidents, accidents or complaints. Two of the care plans we looked at should have included reference to the need for half hourly checks, another should have advised staff to steer one person away from another after meals.

Sometimes it was not clear whether care workers had read people's care plans. For instance, we observed an agency care worker helping a person to mobilise; the person was uncomfortable during the process. We looked at the person's care plan and found that two care workers should have been assisting them. We spoke with the care worker about this, they told us they had not realised this was the case and they had previously helped this person to move on their own. They said that they would look at the care plan without delay.

Even when staff were familiar with people's care plans, they were not always able to follow them. One person had expressed anxiety to staff about living with dementia. To maintain their emotional wellbeing, their care plan instructed staff to spend time chatting with the person and to give them a hug if they were feeling low. During our inspection we did not notice staff spending time talking with the person. We asked a member of staff about this. They said, "We don't really have a lot of time for that. If [the person] asks for some company, we'll spend a few minutes with [them]."

Care staff were expected to review care plans monthly. There was no evidence of involvement from the person who used the service or their representatives. We found one care plan which had not been reviewed since March. It was clear that, when reviewing, staff were not routinely checking accident and incident logs or other relevant documents in order to update the information in the care plans. This resulted in omissions.

These factors contributed to a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, some staff had a good awareness of people's needs and knew each person individually. For instance, they knew to keep two people apart who did not get on and also knew that two friends always preferred to sit at their own table at mealtimes. One agency care worker observed someone was slouching in their chair and spoke kindly to them asking if they could help them to sit up. Another member of care staff demonstrated good diversion techniques when a person became agitated, helping them to calm down and avoid causing distress to others.

People who used the service had their needs assessed before admission. A few people had had their needs reassessed by visiting healthcare professionals since

Requires improvement

Is the service responsive?

admission. We saw some work had taken place to compile information about people's life history and personal preferences in a document called 'This is me' and established staff had committed much of this information to memory. Meeting minutes showed the service was in discussion with an external organisation which helped individuals to develop their own life story booklet.

There was a relatives' information board. This displayed details of past and forthcoming activities that people were encouraged to take part in, such as a barbecue for people who lived there, their friends and family, and members of staff.

A time table of activities was available and we observed a session to encourage mobility delivered by an external organisation. A part-time activities coordinator arranged a variety of group and one to one activities, but relied on care staff to carry most of them out. We saw this was hard for them to achieve alongside their personal care duties, especially as many people needed support to engage in any way. We noted that as soon as the activities coordinator exited the room the energy they had generated quickly disappeared.

Pet therapy had been provided and we saw that people had been able to keep photos of this in their bedrooms as a keepsake. One person we spoke with said, "Oh yes I loved having the animals here, I hope they come back soon." Indoor activities had included reminiscence sessions, bingo and a tea party. A team leader commented, "People get some stimulation but not enough."

During our inspection, we did not notice any organised activities taking place on the first floor of the home. We asked a member of staff about this. They said, "We're so short staffed but we do have organised activities on the ground floor although encouraging people to take part is difficult."

When we asked if anyone was assisted to visit the garden square across the road from the service, staff said this was rarely possible, due to staff shortages. However, we observed a member of domestic staff walking in the park with someone who used the service and there was evidence of occasional outings arranged by the activities coordinator. A team leader described how someone was supported to go out to buy their daily paper in a way that reduced risks to them, but maintained their independence. The person concerned confirmed this to us.

The provider had an appropriate policy and procedures for making complaints. The provider's new database was able to record and track formal complaints and informal concerns. None had been recorded in the system to date, but managers were aware of how the system should be used in future. Only three complaints and concerns had been logged prior to the introduction of the database and a senior manager acknowledged staff members needed to get better at recognising them so they could be followed up.

Requires improvement

Is the service well-led?

Our findings

We found senior management to be exceptionally open, creative and responsive. They had a clear vision for the service which put people who used the service at the heart of everything they did. When we queried the frequency at which care staff received supervision they immediately investigated and, before the inspection was completed, provided detailed information showing that we were correct in our view that this was not happening in line with their policy. This demonstrated a high degree of honesty.

During the past year the provider had not managed to retain a manager for the service and this had had a major impact on the quality of care, although they had ensured temporary managers were in place to try to fill the gap. Another new manager had recently been appointed and was working their notice in their current job. An agency manager had started work the week before the inspection in order to cover the gap. There was evidence of the provider building local links to better support their care home managers. Senior managers had also consulted larger providers to find solutions to recruitment issues.

Some staff told us they were confused about who was in charge of the service, others were well-informed. A care worker said, "The new manager seems to know what she's doing, she's visible on the floor. We were all invited to a meeting recently to meet her but we were too busy to attend." Two staff members told us they found the provider to be supportive when they had personal difficulties; others expressed suspicion of management actions, equating changes in practice to cuts in service.

Some staff said they thought management did not listen when they mentioned issues such as short staffing. We saw evidence in board reports that senior managers did respond whenever they became aware of problems and they also tried to pre-empt them. We concluded communication, exacerbated by the turnover of managers, was the issue rather than lack of responsiveness.

We found a lack of coherent leadership when we arrived early in the morning. An agency care worker had failed to turn up for a shift and no one on duty felt able to do anything about it until the team leader started their shift one hour later and contacted the agency. A night care worker said, "This is a typical morning for us."

Senior managers told us they were determined to only appoint good candidates to posts. Some recently appointed staff were amongst those who impressed us with their caring approach. Recruitment was proving to be a slower process than anticipated and the quality of the service was suffering in the meantime, due to leadership changes within the service and an over-reliance on agency staff. We saw there was an attempt to match agency staff to vacancies to maximise consistency, but this had not prevented lots of staff changes over the summer period.

We were made aware of several creative developments in the pipe-line which should improve the recruitment situation, but, at the time of the inspection, the lengthy transition period was negatively impacting on the care of people who used the service.

The underpinning processes to support high standards of care were in place. Policies and procedures met the standards set by CARF, an independent organisation focused on quality improvement. Central record keeping was commendable, such as that for safety checks and maintenance. The nominated individual for the service ensured the Care Quality Commission was kept up to date about notifiable events and when queries were raised by us we found they were responded to fully and frankly.

Although care staff were observed to spend time completing records on each shift, often staying on beyond their allocated hours to do this, we found there was a culture of passing on information at handover or in the daily working records, rather than amending key documents such as care plans or risk assessments. For example, following an incident, staff were asked to encourage two people who used the service to sit apart in the lounge. A longer standing staff member told us this had been emphasised at several staff handover meetings soon after the incident occurred. However, many staff members had only recently started work within the service and they were not able to obtain this information from the relevant care files.

The provider held regular meetings with relatives and we saw actions were followed through. The provider was revamping its annual survey to make it more relevant for people who used the service and their families. Staff meetings had been held fairly consistently despite the management changes, there was evidence of lessons learned from the inspection of the provider's other care

Requires improvement

Is the service well-led?

home had been shared with staff in this service. However, all the minutes seen demonstrated the lack of staff continuity, as very few participants had remained the same.

The provider conducted a range of quality audits and had picked up on many of the issues we found. We saw staff meeting minutes which showed staff had been made aware of them and asked to adjust their practice accordingly. Implementation of the required changes had been hampered by the lack of a consistent manager who could give attention to detail and identify who or what was not working well.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person must enable and support relevant persons to understand the care choices available to the service user; enable and support relevant persons to make, or participate in making, decisions relating to the service user's care; when meeting a service user's nutritional and hydration needs, to have regard to the service user's well-being. Regulation 9 (3) (c) (d) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person must ensure that persons providing care have the competence, skills and experience to respond appropriately to the fire alarm. Regulation 12 (2)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. They must receive appropriate support and supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (1) (2) (a)