Ranc Care Homes Limited

Manton Heights Care Centre

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 06 June 2018. During our last comprehensive inspection in September 2015 we rated the service as 'Good'. During this inspection the rating changed to 'Requires Improvement'. This is because we identified some improvements were required to ensure the service provided a good quality service to people who lived there. This is the first time the service has been rated Requires Improvement.

Manton Heights is a 'care home without nursing'. 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.

Manton Heights accommodates up to 79 people in one purpose built premises across three separate units. There is a fourth unit which is currently not in use. One unit is primarily for people with needs related to living with dementia and the other two units support people with residential needs. At the time of the inspection there were 64 people living at the home.

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

The provider had effective recruitment processes in place. Although we identified some gaps in the employment history for some staff, administrative staff were aware of this and work was underway to address this. There were sufficient numbers of staff to support people but some lacked the skills and knowledge to do this safely and effectively.

Staff understanding of their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) required improvement. Staff did not always gain people's consent before they provided care or support to them.

Risk assessments were in place that gave guidance to staff on how risks to people could be minimised without compromising people's independence. However, these lacked detail in some instances and were not always regularly reviewed.

Staff supervision was provided regularly. However, training to enable staff to support people well was not up to date and some staff lacked skills in relation to people's specific needs.

Staff engagement with people was varied; some staff spoke kindly and were respectful to people whereas others were task orientated and were not respectful in all their communications with people.

Care plans took account of people's individual needs, preferences, and choices but lacked sufficient detail to ensure staff were able to meet people's needs well in all areas.

The provider's values were not known or understood by all staff and the culture was task oriented and did not put people at the heart of the service. The registered manager aimed to promote a person-centred culture within the service but a clear strategy for how this would be achieved was required.

The provider had quality monitoring processes in place to ensure they were meeting the required standards of care, but although many of the issues identified at this inspection had been identified, action towards achieving the necessary improvements was not clearly in evidence.

People were supported to pursue their interests.

The provider had a formal process for handling complaints and concerns.

Medicines were administered safely and people were supported to access health and social care services when required.

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

There were systems and processes in place to safeguard people from harm but staff understanding of their responsibilities in relation to this varied.

Risks to people were assessed and their safety monitored and managed so they could be supported to stay safe. However, these assessments were not always reviewed and updated as necessary, and staff did not always follow the guidance in place.

There were systems in place to support learning from when things went wrong but this did not always happen in practice.

There were sufficient numbers of staff to support people to stay safe.

The provider had policies and systems in place to protect people from the risk of infection.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not all have the skills and knowledge to support people well. Training was not up to date for all staff.

Staff did not have a good understanding of the principles of the Mental Capacity act, and consent was not always sought before providing care.

People were supported to eat and drink a nutritionally balanced diet.

People's needs were met by the adaptation, design and decoration of the premises.

People had access to healthcare services and on-going healthcare support.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with kindness, respect and compassion.

People's privacy and dignity was not always respected.

People were not always supported to make decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always receive personalised care that was responsive to their needs.

People's wishes for the end of their life were not always documented within their care plans.

A wide range of activities were provided which had been developed in response to people's interests.

People's concerns and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led

The culture of the service was not person centred and a robust strategy to change this was not evident.

Systems to monitor the quality of the service were not used effectively to ensure that people received a consistently good service.

The service worked in partnership with other agencies but communication between the service and some other professionals needed to be improved to ensure joined up, good quality care was received. □

The people who used the service, the public and staff were engaged and involved in the service.	

Manton Heights Care Centre

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 comprehensive inspection took place on 06 June 2018 and was unannounced. The inspection team was made up of two inspectors, an assistant inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included the previous inspection report and notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about. We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we also contacted the local authority to seek their views about the service provided at Manton Heights.

In the weeks preceding this inspection we received notifications from the service in relation to incidents that had taken place at the service as required by law. We also received concerning information from a number of other sources, including members of the public and the local authority. Many of these concerns related to the quality of the care, including some about the treatment of wound care and the prevention and treatment of pressure ulcers. As this inspection was due to take place, this information did not change the timing of the inspection. It did, however, change the composition of the inspection team. We looked at some aspects of the service during the inspection with the support of the Specialist Advisor.

During the inspection, we spoke with 15 people who used the service, seven relatives and friends, two visiting professionals, the registered manager, the deputy manager, five care staff and the activities coordinator.

We looked at the care records for 10 people who used the service, the recruitment records for four staff employed since the last inspection and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they managed, assessed and monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Staff had received training in safeguarding people, although refresher training for some staff was not up to date. Staff we spoke with had varied levels of understanding about their role and responsibilities regarding safeguarding people from potential harm or abuse. When asked, not all staff were clear about what signs might indicate a person was at risk of, or had experienced harm. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when needed. However, some staff were unable to tell us about external agencies that concerns about safeguarding should be reported to. This meant that people were at risk of concerns not being identified and dealt with appropriately.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were personalised risk assessments for each person to give guidance to staff on any specific areas where people were more at risk such as falls, nutrition, pressure areas, and mobility - including those for people supported to move by staff. However, we noted that these assessments had not always been reviewed regularly, and when changes had been made, staff did not always change the support they provided. For example, one person had lost weight, and although the risk assessment was changed to indicate that they needed to have a weekly rather than monthly weight check, this had not happened. This placed them at risk of further weight loss because staff were not monitoring their weight as outlined in their risk assessment.

Following the inspection, the provider shared information to demonstrate they had a system to analyse incidents and accidents and support learning to make improvements to the service. For example, by monitoring the number of falls a person had and analysing the circumstances of each fall, the service was able to take action and put measures in place to reduce the number of falls the person had in future.

There was guidance on how staff should manage 'as and when required' (PRN) medicines although this was not always sufficiently detailed, particularly in relation to PRN anti - psychotic medicines. This meant that people were at risk of PRN anti - psychotic medicine not being administered in line with the intentions of the prescribing physician. The guidance to staff about when it would be appropriate to administer this medicine was insufficient and the decision was seemingly left to staff on duty at the time. This meant there was no clear framework in place to ensure that this medicine was administered as a last resort after other clearly defined strategies had been tried and failed. This left people vulnerable to the risk of inappropriate care and ultimately, over medication.

People's medicines were otherwise managed safely because there were systems in place for ordering, recording, storing, auditing, and returning unrequired medicines to the pharmacy. Medicines were administered by care staff who had been trained to do so. We reviewed a sample of medicine administration records and saw that these were completed correctly. We checked a sample of staff recruitment records

and, although pre-employment checks to ensure only suitable staff were employed had been completed, enquiries into gaps in employment history had not been recorded for all staff. We discussed this with the home's administrative staff who showed us evidence that this matter was being addressed.

On the day of the inspection there were enough staff on duty and people we spoke with confirmed this. We noted that call bells were answered in good time and people did not wait long for assistance. One person said, "They like us to use the bell if we need anything, and they don't take long to come and help."

People and their relatives told us they felt safe at Manton Heights. One person said, "Yes, there's always someone around. I feel safe – it just feels that way." A relative told us that their family member had been supported well in relation to being at high risk from falls, and because of this they believed they were safe at the service.

The service was clean and well maintained. Housekeeping staff had a robust system in place to ensure that the premises remained clean and that people were protected from the risk of infection. Staff had sufficient understanding of good practice in relation to infection control, and were seen to follow current guidance during the course of our inspection. We saw they used personal protective equipment (PPE), such as gloves and aprons when assisting people with personal care, and disposed of these appropriately once the task was completed. Waste and laundry were managed appropriately, and staff were seen to wash their hands before and after providing support to people.

Requires Improvement

Is the service effective?

Our findings

Before the inspection we received concerning information in relation to how the service and other healthcare providers worked together to meet the health-related needs of people who used the service. This was particularly in relation to skin integrity and pressure relief. We discussed this with the registered manager who confirmed that steps were being taken to address issues such as poor communication and information sharing that had led to people not receiving care of an appropriate standard. During the inspection we also checked how people were cared for in relation to pressure care and found that they had sought appropriate advice from external professionals. Appropriate equipment was in place as well as repositioning plans if needed and monitoring records to ensure this was done as planned. We saw from records that people had support to access health care from community health professionals such as opticians, GPs and chiropodists, and the complex care team.

Staff did not all feel that they received sufficient training to enable them to meet people's needs effectively. Much of the training provided was on line e-learning (electronic learning through a computer) as opposed to face to face learning. Although some face to face training was provided, some staff felt this was not in depth enough to equip them with the skills they needed to do their jobs well. We looked at the training record for all care staff working at the service and found that a significant number of staff were not up to date with refresher training in training courses the provider considered mandatory.

The provision of training relevant to the needs of people living at the service, such as dementia awareness and the management of challenging behaviour had not been completed by all staff. One member of staff confirmed this by telling us, "The training is nearly all e-learning… and I have not had face to face dementia or challenging behaviour training." The member of staff was not able to explain clearly how they supported someone who could display behaviour that may be perceived as challenging. Another member of staff told us, "A lot of staff need more training especially challenging behaviour." They went on to add, "We don't know what to do when residents become loud and difficult." We observed that, particularly on the unit supporting people who lived with dementia, some of the staff lacked the skills required to meet the needs of the people they were supporting. Some of the people living on this unit had complex and challenging support needs, and although staff were not intentionally negligent or unkind, it was clear that they did not have sufficient knowledge of working with this client group. During our inspection we saw many occasions on which staff demonstrated a lack of the skills required to meet people's needs. These included using an impatient or sarcastic tone when speaking with people, continually moving people away from areas without explanation, repetitively saying 'no' and 'stop it' to people when they became agitated rather than attempting to engage positively to distract the person, and outpacing people when walking with them, so that they were being led along by a member of staff who was several paces ahead of them. This demonstrated that the lack of effective training directly affected the quality of care provided to people, who were being supported by staff who did not know how to meet their needs.

We discussed this with the registered manager, who confirmed it had been identified that further training was required in relation to the specific needs of people living at the service. They told us that the provider had taken steps to address this, and the week before this inspection, some staff had completed dementia

awareness training delivered by the Alzheimer's Society. More sessions were in the pipeline for all staff to whom this was relevant. A drive to encourage staff to complete refresher training had started and numbers of staff who had completed this had started to rise. However, at least some of the staff who were involved in poor practice had attended this training. This demonstrated that staff required follow up support and checks to ensure their competency and understanding after such training events, in order to apply the learning to their work.

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

The provider had an induction process for newly appointed staff and staff we spoke with confirmed this had been useful in supporting them to familiarise themselves with their role and the needs of the people using the service.

The provider had a policy in relation to the provision of formal supervision within the service. We saw from records, and staff told us, that supervision was provided in line with the provider's expectations.

Staff practice in relation to asking people for their consent before providing care varied. We saw that some staff routinely asked people for their consent before providing support, but others did not do so; leading people without saying where they were going and putting clothes protectors on people at lunchtime without checking that this was wanted. In addition, care plans and associated records had not always been signed to confirm that people (or their representative where appropriate) were in agreement with the contents.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that where it was assessed as appropriate, DoLS applications had been made to the supervisory body in line with legislative requirements. We saw from records that, where a person was believed to lack capacity to make a specific decision, capacity assessments were completed and best interest decisions were made by the relevant professionals and family members. This process had been completed by the management team. Staff we spoke with did not have a good understanding of the MCA or DoLS, and with the exception of one member of staff, were unable to tell us how this legislation impacted their work.

We observed the support offered to people at lunchtime and found that the quality of care was not consistent. The approach to lunchtime was task orientated. Although there were enough staff available to support people with their meals, there was little conversation or attempts to socialise made, beyond the basics of offering and accepting food. We noted occasions when people were supported to eat by staff who stood over them and did not engage appropriately. However, we also noted that other staff sat at eye level with people they supported and engaged well. In particular, we saw that one person who was eating in their

room received positive, patient support from the member of staff, who took time to ensure the person's mealtime experience was good.

Choices were not actively promoted by staff serving the meals. Staff served vegetables with the meal without checking which vegetable each person wanted, and served sponge pudding with custard, again without checking whether or not people wanted it. We were told that people made their choice of meal the day before, which was not ideal for people living with dementia, who may not recall what choice they had made. The menu was not on display to help remind people either.

The feedback we received from people about the food was positive. One person said "Yes, I get enough to eat; too much really. Sometimes I remind them I only need a small one." A second person said, "The food is good. It always looks nice." A relative confirmed that their family member had a choice of menu and if they did not like the options available, they would be able to have an alternative. A choice of drinks and snacks were offered to people regularly throughout the day. We observed that there was a choice of hot meal provided at lunchtime. Food was served warm and appeared to be of a sufficient quality and quantity. Most people seemed to enjoy their meal.

Information had been sought from people during their initial assessment regarding their food preferences and dislikes, as well as any allergies, specific dietary requirement related to health conditions, cultural or ethical beliefs and whether assistance was needed with eating. Care plans were developed which took account of this information and kitchen staff also kept a record of this information to enable them to meet people's dietary needs.

People's needs had been assessed prior to admission in line with legislation and up to date guidance. This information had been used to develop a care plan to support staff to understand how to meet the person's needs. Care plans we viewed shows this had taken place although, in some instances there was little evidence of involvement in this process by the person or their relatives (where appropriate). The assessments identified people's needs in relation to issues such as eating and drinking, mobility, skincare, emotional wellbeing and mental health personal care, specific health conditions and communication.

We noted that some bathrooms had been used to store equipment such as wheelchairs, hoists and a plastic mattress. This had been identified by the manager during a recent audit, but had yet to be addressed. Manton House is a purpose - built premises designed across two fully accessible floors and a good size garden. It was positive to observe facilities such as a cinema room, a hair dressing salon, a library and a quiet area. The weather on the day of the inspection was dry and warm and people were seen to make use of the outdoor space. There were also private areas for people and their families to make use of should they wish to meet somewhere other than the person's bedroom. Some work was in progress to create a more dementia friendly environment, with the use of themed areas to support people to orientate around the building.

Inadequate

Is the service caring?

Our findings

People and their relatives gave mixed responses when asked whether staff were caring and kind. One person said, "Care staff don't talk. They can be rude." Another person said, "Day staff are fine but night staff are different. They talk to each other not to me." This person went on to say that staff used their mobile phone when providing support and that they sometimes spoke to each other in a language the person could not understand which left them feeling uncomfortable. However, some people felt differently and made comments such as, "Staff are really good, couldn't get better." And, "I have no problems with staff, they are really, really good here."

The mixed feedback from people was also reflected by our observations. During the inspection we found that staff did not always engage in a caring or respectful manner towards people. For example, when one person stated that they did not want their drink, using a sarcastic tone, a member of staff said, "Of course you don't. Now come on drink it." They made no attempt to offer an alternative drink for the person or to find out what the problem with the drink was.

On another occasion, a person became distressed when a member of staff tried to prevent them from grabbing a tin of biscuits. The member of staff became involved in a tussle with the person, attempting to physically take the biscuit tin from them. This resulted in the person becoming agitated and slapping the member of staff. At this, another member of staff intervened, but instead of using positive strategies to distract the person, they physically placed them in an armchair and said, "No. Stay put." They then proceeded to push the armchair, with the person still in it, across to the other side of the room." This achieved nothing to reduce the person's agitation, and they jumped up and continued to walk around the unit in a distressed state. Over the course of this inspection we noted that staff said "No" to this person repeatedly and the number of positive interactions this person had were few. We did, however, note that certain individual staff successfully supported the person to be reassured just by spending some time walking with them, rather than attempting to restrict their movements.

To address people by their preferred name is a way to demonstrate respect. As part of how their dementia presented, one person used repetitive language in place of full sentences. During the course of the inspection, we overheard staff referring to this person by the repetitive language they used, rather than by their name, "Here comes (Repetitive language)" rather than, "Here comes (Name of person)." This did not demonstrate that the person was valued or afforded any respect. Similarly, we overheard numerous occasions in which staff spoke to each other about people in the presence of others and the person themselves. This showed no regard for people's feelings or their right to privacy.

A significant number of people living at the service had complex support needs, including those associated with advanced dementia and with displaying behaviours that may be challenging to others. We found that the lack of training in dementia and in managing behaviour, as well as a lack of clearly defined proactive strategies and guidance for staff, significantly contributed to the poor practice on the part of individual staff. As such, what we observed was not deliberate unkindness, but more an indication that staff were out of their depth and did not have the skills or guidance from the provider on how to meet people's needs.

However, whether intentional or not, the impact of this on the people concerned was that the service they received was not caring, their behaviour was not understood and interactions increased the likelihood of these behaviours escalating. Consequently, their care needs were not responded to in a personalised manner. They were treated disrespectfully and in an undignified way and their physical and mental well-being was frequently unmet.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed some positive interactions between people and staff. For example, one person who lived with dementia was sitting at the lunch table with their arms so full of toys it would have been impossible for them to eat. A member of staff approached them, and clearly recognised the significance of the toys to the person and just said very quietly to them, "(Name?) Would your children like to sit over there (Pointing to a nearby area), just for lunchtime?" The person happily agreed and was able to eat their lunch comfortably. This demonstrated acknowledgement of the person's reality and showed respect for them and their needs.

People we spoke with said they were supported to make decisions about their care, such as whether or not they wanted a shower, what they wanted to drink and what time they wished to go to bed.

People were supported to maintain contact with friends and relatives, and relatives we spoke with told us they felt welcome and involved in their relative's care. We saw a number of visitors during the day and noted that they appeared comfortable and relaxed when speaking with staff.

Requires Improvement

Is the service responsive?

Our findings

Although care plans were developed following an assessment of people's needs, these were not always sufficiently detailed to ensure people received personalised care. For example, we noted that the care plan for one person contained no information about the reason for them being prescribed strong pain relief. Although the section about medical conditions had been completed, there was no information about a condition that might be treated in this way. The registered manager addressed this matter in relation to this individual person immediately following the inspection and sent us a copy of the document that was put in place. However, an audit of care plans to ensure they contain all relevant information would be beneficial.

Care plans contained inconsistent information. For example, one person's plan stated they had Alzheimer's disease in one section, whereas elsewhere it was recorded that they had vascular dementia. These two different types of dementia can present in very different ways and the support required by the person may be different depending on which diagnosis was accurate. There was an absence of detail about how people's dementia affected them in each care plan looked at for which this would have been relevant.

Care Plans to support people who displayed behaviour that may have a negative impact on themselves or others were insufficiently detailed to enable staff to support them appropriately. There was little information regarding triggers for behaviour, signs of escalation, or proactive strategies to reduce the likelihood of incidents or to de-escalate an incident that could not be prevented. The behaviour support plans we reviewed issued guidance such as 'try to distract' but did not detail how staff might successfully do this. Staff were encouraged to record incidents where behaviour like this had been displayed, but there was no evidence to show what the purpose of recording this was. There was no record to show that these incidents were analysed to identify whether the approach taken by staff was effective or to decide whether external support was needed to develop a different approach.

The care planning system used by the provider was lengthy and was used generically so that, even when people did not have support needs in a particular area, this part of the document remained in place. This could lead to information being overlooked by staff because a number of pages in plans were left blank in between pages that were completed.

Daily records and various monitoring charts, such as food and fluid intake or repositioning charts were in place to record the care provided by staff on a daily basis when it had been assessed as necessary. However, we noted that these were not always completed fully. This meant the forms were not used effectively to monitor people's nutritional intake and ensure their individual needs were met. We also noted that where people's needs had changed and they required weekly rather than monthly weight checks, this had not been picked up by staff, who had continued to weigh them monthly. This highlighted that, although care plans were updated, staff would not always keep themselves up to date with any changes required.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an established activities team who had developed a good programme of events and activities to support people to maintain their interests and hobbies. The activities coordinator made links with external organisations who supported the provision of interesting and diverse events over the year. We saw that people had participated in a celebrity photo shoot and many eye-catching photographs of this were displayed throughout the corridors. There was a gardening club and a 'bug hotel' activity, opportunities to go out on trips and go to events set up at the service. In the morning we saw that people were participating in a flower arranging activity, and the member of staff who was facilitating this told us that this was supported by a local supermarket that donated all the flowers for the activity once every week. People and relatives we spoke with felt there were opportunities to participate in enough activities to maintain their interest and to feel stimulated during the day. Some staff we spoke with commented that people who were living with dementia did not get equal access to activities and that activities provision was focussed more on people who engaged easily with tasks. One member of staff said, "None of the people on this unit had the chance to go (on a trip that was taking place that afternoon)." However, we noted that the flower arranging took place on the unit for people living with dementia and although some people did not engage with the activity fully, it was clear that others participated to varying degrees.

The provider's care planning systems contained a section about people's needs and wishes for the end of their life. The information recorded varied in quality in the records we looked at. For most people, a current decision regarding resuscitation was recorded, and where people did not want to be resuscitated, the appropriate Do not attempt cardiopulmonary resuscitation (DNACPR) authorisation was kept on the person's file. For others some basic detail of funeral plans and relatives to contact in the event that the person was at the end of their life were recorded. In all but one record looked at, where the end of life information was more detailed it focussed on the process to follow when a person is coming to the end of their life. There was little information about family involvement, where the person wished to be cared for, and any spiritual or cultural beliefs that should be taken into consideration at this time in the person's life. This information required review to ensure people could be supported to have a comfortable and dignified death that was in line with their wishes when the time came.

The provider had an up to date complaints policy and procedure and people we spoke with knew how to make a complaint should they find it necessary. One person said, "I can speak up if there's a problem I would tell him [the registered manager]." There was a record kept of each complaint received and we saw that each one had been investigated and responded to in line with the provider's policy. This record enabled the manager to monitor complaints and identify actions that were required to make improvements to the service.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, supported by a deputy manager and team leaders for each unit.

The provider had not taken sufficient steps to ensure their values were clearly identified, understood and shared by all staff. As a consequence, people did not receive kind, compassionate and personalised care. The service was described by the provider as offering specialised dementia care, but they had not ensured that staff had sufficient training or guidance in relation to meeting the needs of people living at the service who had a diagnosis of dementia. People living with dementia were not supported by staff who demonstrated empathy or sufficient skills to meet people's needs.

Following the inspection the provider told us that there were two designated champions for dementia care (staff identified who to cascade learning about dementia care throughout the staff team) and that training events relating to dementia care had been offered to staff. However, this had little positive impact on staff practice on the day of the inspection. The lack of specific guidance in relation to the individual needs of people using the service meant that staff were not applying learning from the training they may have undertaken.

The registered manager was aware that the culture of the service was not sufficiently person centred and said that this was a priority in terms of service development. Some steps had been taken such as the rolling out of targeted training in relation to people's support needs. However, this was not sufficient on its own to challenge the existing culture in the service and more work was needed to develop an ongoing strategy so that good practice was fully embedded and sustained.

Staff gave mixed feedback about the support they received from the management team and the provider and some described staff morale as low. One member of staff said "I love it (working here) with this manager. He is so positive and always just says, give it a go." However, other staff did not feel the same way. One member of staff said, "I don't feel supported." They went on to say they were concerned that senior staff were not fully aware of issues faced by staff on the unit they worked. It was clear from our discussions with staff, observation of staff practice and the review of care plans, that some staff were not confident to manage the challenges of their role, and that further support, guidance and training was required to enable them to develop their skills.

Although the provider had systems in place to assess and monitor the quality of the support provided these were not used effectively to drive continuous improvements to the service. We looked at the most recent provider audit completed in April 2018 and found that many of the issues identified at this inspection were also noted in this audit. An action plan was not available to review on the day of the inspection to identify what improvements were in progress to address the shortfalls found by the audit. Following the inspection, the manager sent us a service action plan, but this did not cover all of the issues identified by the audit. Therefore, we concluded that the audit was not used effectively to drive improvement. The management team also completed a number of audits on a daily, weekly and monthly basis. These included checking people's care records to ensure that they contained the information required to provide appropriate care.

Other audits included checking how medicines were managed, whether staffing files and training records were well maintained, infection control, mealtime experience and health and safety checks. Although these audits were completed regularly, we found they also had not always been effective in identifying the issues identified at this inspection.

Records showed that people had opportunities to provide feedback on the service through a number of means including surveys and resident's meetings. The action plan developed following the survey was sent to us after the inspection as it was not available to review on the day. Although it addressed some of the issues raised, it did not identify what action was planned to address other issues of concern that people had fed back to the service. This called into question whether or not people's views were being used effectively to make improvements to the service.

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

During the inspection we observed people who used the service interacting with the registered manager. It was clear that he had a visible presence in the home and that people felt comfortable to speak with him. One person told us, "He pops in sometimes and has a chat." Another person we spoke with could not recall the registered manager's name but said, "He is a good manager and he listens."

Staff meetings took place on a regular basis and staff told us they had the opportunity to contribute to discussions and to share their views about the service and how improvements could be made.

The registered manager submitted notifications to the Care Quality Commission as required by the Regulations.

The registered manager told us that they were taking steps to ensure they worked together in partnership with other key agencies and organisations such as the local authority, hospitals and other health professionals to ensure the provision of joined-up care. They acknowledged that shortfalls in the communication systems between partners had previously resulted in people not experiencing good care, and demonstrated a commitment to ensure this was improved in future. We saw that the manager had changed internal recording systems to ensure that staff sought feedback from visiting professional who were involved in people's care.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care that met their individual needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with kindness and respect. Their dignity and privacy were not protected a

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not understand what constitutes abuse, or their role in protecting people and reporting concerns

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assessment systems were not used effectively to address shortfalls in the service and take action to address them. The provider did not have a sufficient strategy in place to support the development of a person centred culture.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff did not have sufficient skills or knowledge to meet the needs of the people who lived at the service.