Sanctuary Care Limited

Basingfield Court Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 03 and 04 April 2017 and was unannounced. Basingfield Court Residential Care Home is registered to provide care without nursing for to up to 52 older people who may also be living with dementia or have a physical disability or sensory Impairment. At the time of the inspection there were 48 people living there, two of whom were in hospital.

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

We were not assured that the potential risks to people from developing pressure ulcers were safely managed. Staff did not ensure professional's guidance was always followed to ensure people received safe care. Staff had not received the required training to safely assist a person with an aspect of their medicines administration. We were not assured that potential risks to people when identified were always managed appropriately. Equipment had not always been maintained to an appropriate standard to ensure people's safety.

People and staff told us there were insufficient numbers of staff always on duty to meet the individual needs of people using the service. There were not always sufficient staff deployed in the event of staff sickness and arrangements to cover staff sickness were not effective. This had resulted in insufficient staff being deployed on some night and day shifts. There were not always sufficient staff deployed to provide people with safe and timely care.

Staff stored medicines securely and within their recommended temperature ranges. Staff signed when creams had been applied to people. We were not assured that a person's allergy information was consistent or correct to protect them from the risk of harm. People's care plans for the management of anxiety did not describe when to use the prescribed medicines for people's safety.

Processes in place to audit and monitor the service were not being used effectively to drive service improvement for people. We were not assured that full and complete data was supplied through the auditing and reporting processes to ensure the provider could effectively monitor the service. The failure to complete any trends analysis of incidents meant opportunities had been missed to identify any trends and patterns for people in order to minimise the risk of repetition. Robust records of people's care were not maintained to ensure their safe care.

People told us they did feel safe from abuse. Processes and staff training were in place to safeguard people. Apart from one incident which was addressed during the inspection, processes were followed to ensure people were safeguarded from the risk of abuse. The provider ensured safe staff recruitment practices were followed.

Staff received an induction to their role; 88% of staff had completed the providers' required training. The provider was aware that staff had not received supervision as required and plans were in place to address this to ensure people were cared for by staff who were appropriately supported in their role.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People did not provide positive feedback about the quality or variety of foods offered. Records showed the issue relating to the quality of the meals was long standing. A person's meal did not meet the requirements of their diet. However, people had a pleasant lunchtime experience and were supported by staff to eat their meals where required.

Staff supported people to see health care professionals as required.

People we spoke with felt that the staff were doing all they could and were kind and caring. We observed positive and respectful interactions between people and staff. Staff were heard to consult people about their care and respected people's decisions. Overall people were treated with dignity and respect by staff.

People were not consistently positive about the level of stimulation provided. There were dedicated activities coordinators who were responsible for organising and supporting people to participate in activities. The level of contact people had with staff would have benefited from being more clearly evidenced in their records.

People had relevant care plans in place but these had not always been reviewed as frequently as required by the provider, action was being taken to address this for people.

It was not clearly evidenced how the needs of those living with dementia were being met. However, staff had either undertaken or were due to complete training to enable them to understand how provision for those living with dementia could be improved. We have made a recommendation about staff training on the subject of the provision of suitable activities for people living with dementia.

People reported they did not always feel listened to. Formal complaints were actioned. However, there was an absence of recording and reviewing of minor concerns so that the service could identify and monitor trends and identify any improvements needed for people.

People and their relatives provided mixed feedback on the management of the service. Staff did not provide positive feedback about the management of the service. Senior staff did not always carry out their roles effectively. The registered manager was now receiving the level of support, guidance and oversight they needed from the new regional manager and the new regional director to enable them to become an effective registered manager.

There was not an open, positive and person centred culture within the service. The registered manager, the regional manager and the regional director were fully aware of the cultural issues within the service and the need to address these to ensure staff began to work as a team to ensure people received good quality safe care and this work had commenced. Actions had been instigated to ensure staff understood both their responsibilities and were enabled to express their views of the service directly to the provider.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the providers to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people in relation to the provision of their care had not always been managed safely.

There were not always sufficient staff deployed to provide safe and timely care for people.

The service was not safe because people were not protected against the risks associated with medicines.

The provider ensured safe staff recruitment practices were followed.

People were safe from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff received an induction to their role and training. The provider was aware that staff had not received supervision as required and plans were in place to address this.

People's treatment was provided in accordance with the requirements of the Mental Capacity Act 2005, to ensure the rights of people who could not consent to decisions about their care were protected.

People received sufficient food but were not satisfied with either the quality or the variety.

People were supported to access health care services where required.

Is the service caring?

Good

The service was caring.

People experienced positive and caring relationships with the staff who provided their care.

People were consulted about decisions in relation to their care.

People were treated with dignity and respect by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had relevant care plans in place but these had not always been reviewed as frequently as required to ensure they remained relevant and up to date; action was being taken to address this for people.

Although there was evidence of the provision of a range of activities people were not consistently positive about these meeting their expectations.

Formal complaints were actioned. Processes were in place to seek people's views. However, people did not always feel their concerns were sufficiently heard and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had processes in place to monitor the quality of the care provided. These were not being used effectively to drive robust and continuous service improvement for people.

The service has not been well managed or well-led. The registered manager is now receiving the level of support, guidance and oversight they need from the new regional manager and the new regional director to enable them to become an effective registered manager.

There was not an open, positive and person centred culture within the service. Actions had begun to ensure staff understood both their responsibilities and were enabled to express their views of the service to the provider.

Basingfield Court Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 03 and 04 April 2017 and was unannounced. The inspection team included two adult social care inspectors, a pharmacy inspector 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. The expert by experience had experience of caring 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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we spoke with a senior social work practitioner and a senior safeguarding and governance officer from the local authority. We also received written feedback on the service from the ambulance service. Following the inspection we spoke with a nurse. During the inspection we spoke with 16 people and two people's relatives. We spoke with day and night staff including 11 care staff, the cook, maintenance staff, domestic staff, the two deputy managers, the registered manager, the regional manager and the regional director.

We reviewed records which included eight people's care plans, four staff recruitment and supervision records, staffing rosters for the nine week period of 30 January to 2 April 2017; people's medicines records and records relating to the management of the service.

The service was last inspected on 17 February 2015 and no concerns were identified.

Inadequate

Is the service safe?

Our findings

Most people told us they felt they received safe care. However, some people's relatives gave examples of when they felt their loved one was not safe, for example, during the recent failure of the hot water system, which had now been rectified for people.

A person's care plan stated they were to be re-positioned at night to manage the risks to them from the development of pressure ulcers. However, there was a lack of evidence to demonstrate how these risks to them were to be managed in the day. The need to check people's pressure areas daily had been raised with staff at the team meeting on 21 March 2017. However this person's records did not show that their pressure areas had been checked daily as required. Two people's re-positioning records were either incomplete, or missing. As a result, we could not be assured they had received the care they needed. Checks to ensure people's pressure relieving mattresses were on the correct setting were not recorded daily. Some people's mattresses had remained on the incorrect setting between checks; therefore they may not have been effective. We were not assured that the risks to people from developing pressure ulcers were safely managed.

Professional guidance about a person's diet had been recorded; but not passed to the chef to ensure they received the correct diet. Another professional had provided guidance that a person was to have bed rest, however, their care plan had not been updated and there was a lack of evidence to demonstrate they were receiving this care. Another person's notes demonstrated they were to be weighed weekly to monitor their weight; but this had not been completed as required, despite the registered manager reminding staff to do so. Staff did not ensure professional's guidance was always followed to ensure people received safe care.

A person's records indicated they self-administered their own medicine; however staff told us they drew up the medicine, which contradicted the care plan. Staff had not received training to do this and there had been an incident; although the person came to no harm, there was the potential that they could have. Following the inspection the registered manager provided written evidence that alternative medicine administration arrangements had been made to ensure this person's safety.

We were not assured that potential risks to people were always safely managed. Staff had informed the on-call manager that there were only three care staff the night of 2 April 2017 instead of the required four. This information had not been acted upon to ensure people's safety. Records demonstrated staff had correctly reported a recent incident. However, staff had not been directed to complete an incident form to ensure the incident was logged and investigated; no consideration had been given as to whether the incident should be reported to the local safeguarding team and no measures had been put in place to manage the risk of further incidents. We requested the incident was reported to the local safeguarding authority to ensure people's safety, which the registered manager did.

The assisted baths in two bathrooms did not have their side panels securely attached. Therefore, there was a risk people could have gained access to the bath mechanism and harmed themselves. Equipment had not always been maintained to a level to ensure people's safety.

The provider's failure to ensure that people were receiving safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us there were insufficient numbers of staff on duty to meet the individual needs of people using the service. Their comments included: "Sometimes I have to wait up to ten minutes or quarter of an hour for staff", "I can wait up to 20 minutes sometimes. Sometimes they come and say 'I'll be back in a minute', but they're not", "He said he waited for so long recently he'd forgotten what it was for by the time they came" and "I don't think there's enough staff."

When we arrived at 06:37 on 03 April 2017 there were three staff on duty, the provider's fire risk assessment required a minimum of four, to ensure people's safe evacuation in the event of a fire at the service. Records showed there were six nights during the period rosters were reviewed when there were only three care staff on duty at night. This had placed people at potential risk of harm in the event of a fire at the service at night. Sufficient staff were not deployed on these nights to ensure people's safety in the event of a fire at the service. Since the inspection the provider has submitted evidence of how they will ensure safe numbers of staff are provided at night. We have informed the fire service to enable them to consider if any action is required

Staff told us, "It was quite difficult last night, we struggled" and "Bells were constant." Staff said there were six people who required two staff to move them and three people who required re-positioning every two hours. Therefore, if two staff were providing care to one person, this left one care staff to cover the call bells. We heard call bells ringing constantly upon our arrival. At 07:15 we saw the tea trolley but there were no staff to serve the tea. Staff confirmed to us later that at least 20 people had not received their morning cup of tea, including two people who needed to be assisted to drink. A member of staff from the day shift arrived early to help administer people's medicines from 07:00. Records showed this was not consistent, on some days the extra member of staff arrived at 07:00 and on others, not until 07:45. Therefore, the extra staff member was not always available at the busy time of 07:00 to 08:00. We saw that as two staff were administering medicines this only left two staff on the floor. At 07:20 one care staff needed assistance to support a person; however they had to wait until their colleague was free, there were then no staff left. Even with the four members of staff on the floor from 07:00 to 08:00 there were not sufficient staff to meet everyone's care needs.

The registered manager told us that up until 13 March 2017 there were eight care staff rostered for the early day staff shift which started at 08:00 and eight for the late shift. This was then changed to nine in the morning and seven in the afternoon to increase the number of staff rostered in the mornings. There were seven days during the period rosters were reviewed when the early shift was down by one member of staff and 20 dates when the late shift was down by one member of staff from the levels identified as a requirement by the provider. Two care staff completed each of the medicine rounds so during these periods the number of care staff available was reduced to seven and five respectively. The number of staff required had not always been deployed to ensure people's safe care and care staff numbers were further reduced during medicine rounds.

There had been high levels of staff sickness. During the period reviewed, staff went sick either before or during the staff shift on 46 of the 63 days. The registered manager told us management provided agency or covered last minute sickness themselves where possible. However, there was negative feedback from staff about the effectiveness of this arrangement in ensuring sufficient staff were deployed. One staff commented, "If short, the deputies will cover but they don't help." It was discussed at the staff meeting of 21 March 2017 that staff could be re-allocated from other duties to cover such incidents. However, current arrangements had not been sufficiently robust or effective.

Staff told us people received their care late due to insufficient staff. One said, "They (people) get upset if they are still in bed at 11:00am." Records of the staff meeting of 21 March 2017 showed some people were not receiving their breakfast until after 11am whilst others were left in their wheelchairs for long periods of time. At the senior staff meeting on 14 March 2017, staff were told to ensure that there was a staff presence in the lounge. We observed on frequent occasions there were no staff in the lounge. At one time 10 people were sat in the lounge with no staff. One person had begun to undress themselves which was not dignified. There were a lack of staff to support this person and we sought them assistance. On another occasion, there were 11 people in the lounge and two people having breakfast. One person told another "To shut up." Although this did not escalate there were no staff in the lounge to diffuse the situation. There were not always sufficient staff deployed to ensure people received their care in a timely manner and were safe.

The provider's failure to demonstrate that sufficient staff were always deployed to meet people's care and treatment needs including in the event of an emergency and staff sickness was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff stored medicines securely and within their recommended temperature ranges. We saw that controlled drugs, which are medicines that require a higher level of security, were not all stored in cupboards that complied with legislation. When we raised this with the provider they undertook corrective action. The date of opening was recorded on the labels of liquid medicines and eye drops, however the insulin for one person lacked the date it had be taken out of the refrigerator and stored at room temperature, therefore it might not have been within a safe date to use.

One person was self-administering some of their medicines. The staff had undertaken with the person a risk assessment to ensure they were safe to self-administer some of their medicines.
Care staff used medicines administration record (MARs) to record when medicines were administered. A care staff member explained how they applied creams to people as part of their personal care. We viewed cream administration records for three people. These records indicated the name of the product, where and when the creams were to be applied. Staff signed when creams had been applied to people.

Each person's MAR or care plan contained details of any information about medicines to be taken on a 'when required' basis and 'how I like to take my medicines'. Allergy information was recorded and consistent for most people. However, it was not recorded for one person. Three people's records were inconsistent, and one of these people was being administered a medicine their records stated they were allergic to. Therefore, we were not assured that person's allergy information was consistent or correct.

The effectiveness of medicines was not appropriately monitored. We reviewed MARs for people prescribed medicines that required blood monitoring. These records contained test results, subsequent scheduled tests, and the exact dose to administer and how to care for them if their condition deteriorated. However, two care plans for the management of anxiety did not describe when to use the prescribed medicines nor were they consistent with the information on the MAR. Therefore, we were not assured that people's behaviours would be responded to consistently.

The failure to ensure the proper and safe management of medicines was a breach of regulation 12 of the Health and Social Care Regulations Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records confirmed they had undergone recruitment checks and these were documented. These included a full employment history, the provision of suitable references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff's suitability for their

role had been assessed for people's safety.

People told us they did feel safe from abuse. Their comments included, "Yes, I feel very safe here." "I've not seen any inappropriate behaviour from the staff." Staff we spoke with were able to identify the types of abuse people might experience. They understood their responsibility to report concerns. Records showed 94% of staff had undertaken safeguarding training. Staff were provided with feedback on safeguarding's at staff meetings. Apart from the incident mentioned earlier in this report, overall, people had been safeguarded from the risk of abuse.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us that there was a variety of training and qualifications offered to them and they spoke positively about the content of the training. Records showed 88% of staff were up to date with the provider's e-learning requirements.

A new member of staff confirmed they had received their induction training and told us, "I feel I had a good induction and sometimes I shadowed a member of the team." There was a staff induction file which contained a comprehensive induction programme covering a range of care topics. However, an agency member of staff told us they had not received an induction on starting to ensure they were familiar with the service and people's care needs. As a result, they might not have been provided with all of the information they required to provide people's care effectively. Overall staff reported they had received an induction to their role.

Most of the staff we spoke with told us they felt well supported in their role but that formal supervision did not take place. Staff also told us that there was little regularity in face to face meetings with their supervisor to get assistance in developing their careers. The registered manager confirmed this was the case and told us this was something they intended to implement. The quality assurance audit of 21 October 2016 identified the need for all staff to have regular supervision meetings on file by 30 November 2016; however, this action had not been completed to ensure staff were formally supervised in their work. The new regional manager told us that the plan going forward was for the registered manager to supervise the deputy managers and the senior care staff. The deputy managers would then supervise the care staff. The provider was aware that staff had not received supervision as required and plans were in place to address this to ensure people received their care from staff who were formally supported.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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 saw from the care records that the service had given consideration to people's needs before applying for any restriction. People's mental capacity had been assessed and the documents describing the type of deprivation of liberty were filed in people's care records.

The majority of the staff had received basic training about the MCA. One member of staff told us, "It's to help make decisions for people with dementia. I've had the training", and another staff member said, "To assess if someone has the capacity to make safe decisions for themselves." Staff had an adequate understanding of DoLS and we saw that throughout our visit they sought consent from people. For example, before lunch was served, people were given the choice of whether they would like to wear clothes protectors. If the offer was

declined, the person's decision was accepted without question, and another time staff met a person walking without their walking stick, which they pointed out to them. Staff offered to get the walking stick for them, but they decided to use the handrails instead and staff accepted their decision.

People did not provide positive feedback about either the quality or variety of foods offered. Their comments included, "Sometimes the food is alright and sometimes it is awful", "Sometimes I can't eat it", "Food is awful, some days it's disgusting", "About two weeks ago the meat was so tough even I couldn't cut it", "Tea is always sandwiches, soup, sometimes beans on toast, fish fingers. The sandwiches are always the same, ham, beef, turkey", "There's enough food but I want some variety." We saw at least four people having to pull food out of their mouths because they could not swallow it.

Records showed the issue relating to the quality of the meals was long standing. The May 2016 resident satisfaction survey showed only 77% of people were satisfied with the meals. People had told the quality assurance team during their visit in September 2016 'the food must improve' and that 'the quality of the meat was an issue.' People provided feedback at the resident's meeting of 8 March 2017 the 'food could be far better' and that the meat was hard. The chef was due to leave and an agency chef was to provide cover whilst a permanent replacement was recruited.

A person had been assessed as requiring a 'fork mashable diet'. The guidance for this diet is that meat should be served in a thick sauce. We observed this person was served corned beef, baked beans and mash, there was no thick sauce. The corned beef was in slices which care staff then cut into pieces and the person's meal did not meet the requirements of their diet. They complained to us that they were offered corned beef for most of their main meals. Although staff told us they had discussed other options with them, as there was no written record of these conversations, or a record of what meals they had been provided with. There was a lack of evidence to demonstrate if the person had been offered suitable alternatives.

The day's menu was printed and placed on each dining table and in the hallway. People were offered two choices for lunch just before it was served. We observed lunch being served both in the dining rooms and the communal lounges. We noted interactions between people and staff were positive and people were talkative and relaxed; people seemed to enjoy their meals despite their comments about the food and had enough time to eat at their own pace. We saw staff sitting and supporting people with their meals in a dignified and sensitive manner. Portion sizes were varied based on individual needs and preferences. We saw one person being served a meal which they had chosen which was not on the menu. People had a pleasant lunchtime experience.

Staff went round with the drinks trolley and offered people a range of drinks and gave people time to choose. However, one person at breakfast said, "They don't have any tangerines this morning." From checking the menu we saw fresh fruit should have been available. The registered manager was not aware of this lack of choice and no action was taken to sort out the healthy option for people, by obtaining some fresh fruit.

People living at the service had a range of health conditions. Staff supported people to gain access to health care professionals as required.

Good

Is the service caring?

Our findings

People told us of the staff, "I think they do a good job here", "The carers are worked to death", "Staff are pleasant", "We have some excellent staff, polite, kind (name of carer) she's very jolly, really cheers me up", "The staff have a good rapport (with people) but there is no time to sit down with them, no 1:1 care and chatting" and "Staff are not reluctant to help."

People's records contained details of their life history and occupation. This ensured staff had information about people and their background, which they could use as a basis for initiating conversations and getting to know the person.

We observed positive and respectful interactions between people and staff. Staff were seen to respond to people in a cheerful and friendly tone. A staff member responded to a call bell and said to the person, "Not a problem, how can I help." Staff provided another person with clear information about what they were doing when assisting them to transfer and explained to the person what they could do themselves. They chatted with the person throughout the process. Most people were able to talk to staff and explain what they wanted. A few people needed staff to take more time and understand the person's own communication style. We saw staff acknowledged people when walking through the communal areas and when sitting down to briefly talk to them.

We observed examples of staff acting in caring and thoughtful ways. For example, when a person at risk of falling got up from their chair, they were asked by a member of staff, "Are you alright? Do you want me to give you a hand?" When a member of staff was moving a person they said, "Mind your hand; sorry but can you put your feet in for me? That's it elbows in." Staff demonstrated concern for peoples' welfare.

People had care plans in place which outlined their needs in relation to communicating. Where people required their call bell in reach this was noted. A person's care plans noted they were deaf in one ear and therefore staff needed to ensure they were on the person's level when communicating with them. We saw staff taking the trouble to kneel down beside people to make sure that they made eye contact when talking to them and listening attentively to what they had to say. Staff ensured they met people's communication needs.

A person's care plan noted 'Can express her daily choices and decisions.' Staff were heard to consult people for example, about what they wanted to eat and drink. Staff respected people's decisions.

We saw that staff respected people's confidentiality and did not discuss people's personal details in front of other people at the service. Staff respected people's privacy and we saw that most staff knocked on bedroom or bathroom doors before walking in. A few times we observed staff failing to knock before entering a bedroom and once staff walked up behind someone and adjusted their trousers without giving them any warning which could be startling. Staff respected people's dignity as they asked people in a discreet way if they needed assistance with their personal care. Staff could describe to us how they would maintain people's dignity when supporting them in their daily personal care routines. Overall people were

treated with dignity and respect by staff.

Requires Improvement

Is the service responsive?

Our findings

Although there was evidence of the provision of a range of activities people were not consistently positive about these meeting their expectations. Their comments included, "There's no activities really at the weekend", "I'd like more outings", "Activities have improved over time", "Nothing much happens at weekends, carers don't do anything" and "They're better at putting on events than they used to be." People also told us, "Tables in the dining room are always made up, so there's no place to play scrabble, read the paper, do a jigsaw, read, play cards etc. They could have a daily crossword or something but they don't", "I don't think they do enough exercise to help them keep mobile" and "The carers have good rapport but no time to sit down with them one on one or to chat."

There were dedicated activities coordinators who were responsible for organising and supporting people to participate in activities. The main entrance had a board displaying the two activities of the day and there was also a printed weekly list of activities. Activities listed included chair aerobics, quizzes and bingo. Staff were observed to encourage people to participate in the bingo session. There were spontaneous bursts of song during the session which people joined in with. Records demonstrated that in addition to the planned programme of activities. Other events had taken place such as: a chinese evening, panto, Charles Dickens Day, bird watch, entertainer, Shrove Tuesday and a visit from the Scouts. A range of activities were provided for peoples' stimulation.

People's care plans documented how they liked to spend their time and instructed staff to spend time with people to stop them becoming socially isolated. However, it was not always clearly demonstrated in their records how often people who remained in their bedrooms were checked upon. We saw staff go in to see people in their bedrooms and there was an initiative for staff to spend ten minutes with people per day sitting and chatting. However, the level of contact people had with staff could have been more clearly evidenced to demonstrate that they were not socially isolated.

People's care plans documented their personal history, individual preferences and the support they needed, which was individual to them. People's routines were documented for example, in relation to them getting up and going to bed. People's care records noted their preferences such as their preferred foods and drinks. However, we were not assured that staff were always aware of people's preferences. One person's notes documented they only drunk water, but their daily care notes noted that they had refused a hot drink on six occasions. However, most staff spoken with were knowledgeable about people's care needs.

People's care plans were supposed to be reviewed on a monthly basis to ensure they remained relevant and up to date for people. We noted this had not always taken place and there were gaps in people's monthly reviews. The registered manager confirmed these reviews had not always taken place as planned. To address this they had introduced 'Resident of the Day.' This was a day of the month when all aspects of the person's care were to be reviewed. However, this was not yet fully embedded within the service to ensure people's care was reviewed every month as required.

People were supposed to have an annual review of their care and this process had commenced for people.

Although there was a lack of evidence to demonstrate all people had yet received an annual review of their care; there was evidence that staff had regular contact with people's families. Records showed a senior member of staff had undertaken training in writing care plans, however, they were still not familiar with which form they should complete following people's annual reviews to demonstrate that they had taken place. Therefore although staff had commenced annual reviews with people this work was not clearly evidenced in people's records on the relevant documents as required by the provider.

Relatives expressed concerns regarding how the needs of people with dementia were being met. One commented, "They don't seem to have done anything to help with his dementia. I've made word sheets with words and pictures to help him remember things and sheets to help him practice his writing as it's starting to go. But they've done nothing and even though I ask them I don't think they are using the things I've made." Another told us they were concerned staff failed to use a communication technique which the person relied upon to express when they were exhibiting certain behaviours. We saw that a person whose memory was failing had a 'communication book'. Their relative said the care staff had put it there and it was a way of encouraging the person to remember what was happening in the day. There were only four notes in it from 13th February 2017 to date. The environment was not particularly stimulating for people living with dementia, for example, in relation to the provision of sufficient items for them to touch and 'fiddle' with, which people living with dementia can find beneficial. It was not clearly demonstrated how the needs of those living with dementia were being met within the service.

Records showed 90% of staff had undertaken the provider's e-learning in dementia care. The registered manager told us three care staff had completed an additional six day dementia care course and the management team had either completed or were due to undertake a leadership in dementia course. Staff were undertaking training to enable them to better understand how to meet the needs of those living with dementia.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the provision of appropriate activities to meet the needs of people living with dementia.

People reported they did not always feel listened to. A relative told us, "Management said to me recently it would help if I made an official complaint but I have my own health issues and I can't stand the stress of the paperwork. I've raised so many things over the years." Another told us, "I stopped going to residents and relatives meetings because no action is taken."

Staff knew how to support people if they wished to complain or share a concern. One staff member told us, "If they felt comfortable with me helping them, I would help them write it out or I could take it straight to the manager." People said they could raise concerns in meetings. There were regular residents meetings the last one of which was held on 8 March 2017. People's feedback was sought on the quality of the cleaning and they were asked for their views about the activities and the possibility of using community transport to go out. People were provided with feedback on issues on issues raised. For example, we saw at the 4 January 2017 residents meeting people were provided with feedback on a previous issue raised about the laundry. Processes were in place to seek people's views.

The provider had a procedure for receiving and handling concerns or complaints and we were provided with a copy. We saw that the procedure had been followed when the manager was dealing with a formal complaint. One person told us, "The meat here has been awful, but it's not their fault, it's the supplier. I've been told they've changed supplier." There was no record of this person's concern. This reflected an absence of recording and reviewing minor concerns so the registered manager could identify and monitor trends and identify any improvements needed to the service. The registered manager told us this had not

been implemented. This meant the provider had missed opportunities to gain feedback on the service.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance team had audited the service regularly. Following each audit, a service improvement plan (SiP) was produced with expected completion dates; however, these had not always been met. One action was for robust care plan audits to be completed by 30 November 2016. We found care plans were not of the required standard to ensure people's safety. The registered manager was 'to keep regular checks on call bell response times.' There was no evidence to demonstrate these checks had been completed. The registered manager was not able to monitor the call bell response times across the entire service, when we requested this information. The service was being regularly audited. However, there was a lack of evidence to demonstrate actions were being completed to drive service improvement for people.

The registered manager told us they completed a monthly audit. The audit documented one pressure ulcer in March 2017 rather than the six that were reported to the Care Quality Commission from January to March 2017. The registered manager also told us that not all safeguarding incidents had been reported on the provider's reporting system. The purpose of this was to enable the provider to monitor the number of safeguarding's raised. The registered manager's audit showed no cases of methicillin-resistant staphylococcus aureus (MRSA) in February 2017, MRSA is an infection. However, there had been a case. We were not assured that full and complete data had been submitted to the provider through the auditing and reporting processes to ensure they could effectively monitor the service and take the required action to drive service improvements.

The registered manager told us there had been an issue with senior staff not reviewing all of the incident reports to ensure the correct actions had been completed and, as a result, they were now monitoring their completion. Therefore, there was a risk that not all incidents had been reviewed for people as required. The registered manager told us they had not completed any analysis of the incidents reported to identify any trends or patterns. Records showed the registered manager was shown at the regional manager's visit on 3 October 3016, how to complete such an analysis. The failure to complete any trends analysis meant opportunities had been missed to identify any trends and patterns for people in order to minimise the risk of repetition and to ensure their safety.

We reviewed the medicines incidents recorded by the service since January 2017. The investigations showed the service had exercised duty of candour to inform people where potential harm had occurred. However, the investigations lacked any evidence of root cause analysis or clustering of similar incidents to identify common themes and learning for staff. Therefore, we were not assured that medicines incidents were fully investigated to reduce the risk of reoccurrence.

The provider showed us their four most recent medicines audits and an audit by their community pharmacy. The service's community pharmacy had undertaken a medicines audit within the last year and a follow up audit was scheduled. However, an action plan had not been developed and implemented in response to any issues identified from these audits, nor had the service's audits identified the medicines concerns we found during this inspection. Processes in place to assess and monitor the safety of medicines in the service were not effective.

The registered manager told us people had been asked to complete a 'resident satisfaction survey' in May 2016. They said they had not been provided with the results, only a poster which showed only 77% of people were satisfied with the meals and services available and only 70% were satisfied with the activities. There was a lack of evidence to demonstrate if people had made any specific comments that needed to be addressed or that an action plan had been completed in response to the survey results to drive service improvement for people.

People's records were not always updated with changes to their care to ensure they were accurate and that people always received the correct care. A person's care records contained conflicting information about their type of diabetes. People's care records did not always provide an accurate record of what had occurred to them. A person's epilepsy seizure chart did not reflect all of the seizures they had experienced to enable these to be monitored. Staff had not completed people's records contemporaneously. When we checked a sample of records on 3 April 2017 we found they had not all been updated with the care provided that morning. Therefore staff may not have been aware of what care had or had not been provided to people. Contemporaneous records of people's care were not maintained to ensure their safe care.

The failure to demonstrate that systems to ensure compliance were operated effectively and that records were accurate, complete and contemporaneous was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives provided mixed feedback on the management of the service. Their comments included, "I feel I can go down and raise anything with the manager", "I know who the management people are", "The manager here, she never comes through at lunchtime and says how's your food etc. I've told the manager she needs to be firmer not just go round to people she likes", "Three managers – what are they doing!" "You don't really know who's in charge."

Staff provided mainly negative feedback about the management of the service. Their feedback included: "I don't have the relationship with the manager's I should have. I don't trust them", "She (registered manager) tells you what you want to hear and action isn't taken", "She (registered manager) lacks control", "No boundaries between management and staff" and "Management are weak."

It is a condition of registration with CQC that the service has a registered manager in place. There was a registered manager registered with CQC to manage the service and two deputies in addition to senior care staff.

The registered manager told us senior care staff and the deputies were required to check that people's re-positioning charts were in place and correctly completed. However, staff tasked with completing these checks had not either carried them out, or reported that where the re-positioning charts were in place that they had not been fully completed, or had ensured appropriate actions were taken to address this for people. A senior member of staff had failed to take relevant actions in relation to two incidents that required action on the weekend prior to the inspection for people's safety. Senior staff did not always carry out their roles effectively.

The registered manager recognised that the two deputies required support to develop their management skills and they were being provided with coaching in leadership.

Records showed management were not routinely rostered to work at weekends, although the registered manager told us they and the deputies did work some shifts. Therefore, people and their relatives did not consistently have the opportunity to speak with management at weekends if they needed to raise an issue.

The registered manager had not always received regular monthly visits from a regional manager to support and monitor them. A regional manager had completed the monthly visit on 3 October 2016. There had then been a gap in the monthly visits recorded until the new regional manager commenced their role at the end of January 2017. Since a new regional manager was appointed and completed their induction they had made four visits to the service in March 2017 to support and guide the registered manager.

The regional director was also new to their post. Both the regional manager and the regional director were visible within the service. They both had a good understanding of the issues facing the service and of the need to provide the registered manager with the correct level of support and guidance to enable them to become effective within their role. The regional manager told us they had instigated weekly meetings between the registered manager and their deputies to ensure the registered manager regularly and clearly communicated their expectations to the deputies and could monitor whether tasks were being completed. Monthly meetings with the senior care team had also recently commenced. The regional manager had attended the staff meeting held on 21 March 2017; outlining that they would be on-site frequently to support the team. The regional manager was supporting the registered manager to implement processes to enable them to improve communications with both the senior team and the staff team.

The regional manager told us they were monitoring the performance of the registered manager to ensure they followed up on actions. The registered manager had also been receiving leadership coaching and development. The regional manager told us improvements had been achieved for example, in relation to staff training. The quality assurance team's last report demonstrated improvements had been made between audits and the service's percentage quality assurance score had increased slightly from 80% in September 2016 to 83% in February 2017. The provider was monitoring the service and was providing the registered manager with the required level of support and scrutiny at a senior operational level.

Staff told us there were issues with staffing and sickness levels. One staff member told us, "Some groups of staff are more effective than others" and "There is bad feeling that some staff get away with doing nothing." Staff told us they did not feel listened to when they had raised issues about the functioning of the team. One commented, "Management can be unresponsive to my requests." A staff member told us, "Sometimes staff put their needs first and go off for breaks." A person had told us they had requested help from a member of the care staff and they had said 'I'm going for my tea break.' Staff told us there was, "A lack of confidentiality when staff were at fault." The quality assurance audit of September 2016 identified that staff would like 'improved team working, communication and to have a more harmonious working environment.' There was not an open, positive and person centred culture within the service.

The registered manager, the regional manager and the regional director were fully aware of the cultural issues within the service and the need to address these to ensure staff began to work as a team for people and this work had commenced. Issues of confidentiality and the culture of the team were discussed with the senior care staff at their meeting on 14 March 2017. Records of the staff meeting on 21 March 2017 showed that staff had been reminded of the importance of following the staff sickness policy and that high levels of sickness would be addressed. It also documented that staff felt that when they had shared their concerns with management about other staff these had not need addressed. In response the provider had arranged for the Human Resources department to commence two weekly surgeries to enable staff to raise concerns directly with them with effect from 6 April 2017. The registered manager was monitoring staff behaviours and where required had commenced the appropriate processes to address these for people. Actions had begun to ensure staff understood both their responsibilities and were enabled to express their views of the service directly to the provider.

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 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that sufficient staff were always deployed to meet people's care and treatment needs. Regulation 18(1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to demonstrate that people were receiving safe care and treatment or that there was proper and safe use of medicines. These were breaches of Regulation 12 (1)(a)(b)(e)(g)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

The provider was served with a warning notice which they are required to meet by 31 May 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's failure to demonstrate that systems to ensure compliance were operated effectively and that records were accurate, complete and contemporaneous was a breach of Regulation 17(1) (2)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

The provider was served with a warning notice which they are required to meet by 31 July 2017 .