Roseberry Care Centres GB Limited

Stephenson Court

Inspection report

Station Road
Forest Hall
Newcastle Upon Tyne
Tyne and Wear
NE12 9BQ

Tel: 01912702000

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6 March 2018 and was unannounced. We also inspected on 7 and 8 March 2018 which were announced.

We last inspected Stephenson Court on 24 October 2017 and found the provider had breached a number of regulations we inspected against. We rated the location inadequate, placed it in special measures and imposed an urgent condition on the provider's registration to prevent admissions. Specifically, the provider had breached Regulations 10, 11, 12, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people were not always treated with dignity and respect. Care and treatment was not provided in a safe way. Care was not always provided with the consent of the person and there was a failure to follow the requirements of the Mental Capacity Act 2005 and associated code of practice. There was a failure to assess, monitor and mitigate the risks to the health and safety of people who used the service and a failure to ensure medicines were managed safely.

The environment was not safe for its intended use. People did not receive suitable and nutritious food and hydration.

Systems and processes to effectively ensure compliance had not been implemented. There was a failure to assess, monitor and improve the quality and safety of the service. There was a failure to maintain accurate, complete and contemporaneous records.

There were not enough suitably competent, skilled staff deployed to meet people's needs. There was a failure to ensure staff received appropriate support, training, supervision and appraisal as necessary to enable them to perform their duties.

Following the last inspection, we met with the provider to confirm their understanding of the concerns and what they would do to improve the ratings for the key questions of safe, effective, caring, responsive and well-led to at least good. An action plan was received from the provider.

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

Stephenson Court can accommodate 46 people in one purpose built building. At the time of the inspection 24 people were using the service, some of whom were living with a dementia.

There was no 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 regional support manager informed us of their intention to apply and since we inspected we have received an application to register as the manager. We have also been informed that since the inspection a home manager and a deputy home manager have been appointed.

During this inspection we found continued breaches of regulation.

Medicines were not managed safely. Provider audits had not been effective in identifying concerns and driving improvements. The medicines optimisation team had also been involved in reviewing the management of medicines and also found ongoing concerns. Since the inspection the medicine optimisation team have conducted a further audit and have noted some improvements.

There were ongoing concerns with regards to staffing and staff deployment. There were significant nurse and care staff vacancies which were being covered by agency staff. People, relatives and staff raised concerns about staffing and the impact it was having on care. Staffing levels were above that identified on the provider's dependency tool, however we remained concerned about the effective deployment of staff.

Care plans were in place, however the quality varied and they were not always reflective of people's current needs. Some were not detailed and some short term care plans remained in place over a month after the short term care need had been met.

Staff said they did not feel supported. We were told supervision meetings should happen every two months however this standard was not met. Induction for new staff was limited and didn't detail time to get to know people and read their care plans.

Training had improved however there were still some gaps, and the provider's target of 85% compliance had not been met.

Two people had not had authorised DoLS in place for over a year. One person's care records documented that they had an authorised DoLS in place when they did not.

The premises had not improved to support the orientation of people living with a dementia. Fire zones had changed and staff had not been informed of the changes and agency nurses who were in charge of the building at night had not been part of a fire drill at the premises. Since the inspection we have received confirmation that agency nurses have completed fire drills.

There had been one complaint which was recorded but there was no outcome detailed.

Quality assurances processes had not been fully implemented which meant there was no effective system to assess the quality and safety of the service. Audits of care plans had not been completed so concerns had not been identified.

Some improvements had been made in relation to meeting people's nutritional and hydration needs. Activities had improved and people were enjoying the increased contact they were having with other people.

The overall rating for this service is 'Inadequate' and the service therefore continues to be in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were continued concerns with regards to the management of medicines.

People, visitors and staff said they remained concerned about staffing levels, and the use of agency staff.

Limited action had been taken to assess, monitor and improve the safety of the service.

Is the service effective?

Inadequate

The service was not effective.

We found ongoing concerns in relation to Deprivation of Liberty Safeguards (DoLS).

Staff had not received the required supervision and support.

The premises had not been improved following a recommendation to research dementia friendly environments.

Improvements had been made to ensure people's nutrition and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People and visitors told us they were generally happy with the care but were concerned about not knowing the staff and felt this impacted on the care they received.

Due to some of our observations and the comments made to us we could not be confident of the caring nature of the provider.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some improvements to care plans had been made however others did not reflect people's current needs, and some were not sufficiently detailed.

Improvements had been made to the provision of activities.

There had been one complaint made, which had been investigated but there was no outcome.

Is the service well-led?

Inadequate

The service was not well-led.

Governance procedures had not been effective at identifying the concerns we noted during the inspection.

The quality assurance system had not been fully implemented to identify areas for action and drive improvement.

Where actions had been identified we were not assured that robust plans had been followed to ensure improvements were made.

There was a continued failure to ensure accurate and compete records were in place.

Stephenson Court

Detailed findings

Background to this inspection

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

This inspection took place on 6 March 2018 and was unannounced. This meant the provider did not know we would be visiting. Further days of inspection took place on 7 and 8 March 2018 which were announced.

The inspection team was made up of one adult social care inspector, an assistant inspector, an Expert by Experience and a Specialist Professional Advisor who was a registered nurse. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We contacted the local authority commissioning team, CCG and the safeguarding adults' team. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with four people living at the service and ten relatives. We spoke with the regional support manager, seven care workers, three nurses, the activities co-ordinator and four members of ancillary staff including a domestic, the administrator, the housekeeper and chef. We also spoke with the director of operations and compliance and the assistant director of quality and compliance.

We looked at care records for nine people and medicine records for eleven people. We reviewed four staff recruitment files and looked at supervision and training information for the staff team. We also reviewed records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational

Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The provider had developed an action plan in November 2017 in response to concerns raised during organisational safeguarding meetings. The provider was developing a specific regulatory action plan at the time of the inspection so we asked them to share this with us once completed. We also requested a copy of the annual health and safety audit, as this was not available at the location, and confirmation that agency nurses had completed a fire drill at the location as they had not done so at the time of the inspection. Since the inspection we have received confirmation that agency nurses have completed fire drills.

Inadequate

Is the service safe?

Our findings

During the last inspection in October 2017 we found breaches in regulations. Risk assessments were not always in place or contained contradictory information which placed people at risk. There was a failure to accurately assess and mitigate risks. Medicines were not managed or stored safely. Items which may present a risk, such as dental cleaning tablets were not stored safely.

Personal emergency evacuation plans (PEEPs) did not contain detail about people's individual needs or the equipment required to ensure a safe evacuation. There were concerns about staffing levels and we observed nurse call bells were not responded to in a timely manner and people spent significant periods of time on their own with no care staff visible.

During this inspection we found ongoing concerns with regards to the management of medicines, the deployment of staff and evacuation procedures.

Protocols were in place for the administration of 'as and when required' medicines. The timeframe for reviews stated one month however we found no evidence that this had been completed. The director of operations and compliance said, "That isn't realistic, three monthly is best practice unless the person isn't needing them then we would expect a review. We need to change it."

Some medicines were used as needed to manage pain or distressed behaviour. There was no detailed information on how to assess a person's pain level, other than 'gives non-verbal signs,' nor was there a description of the behaviour people may display to show they were distressed or agitated. One person had been prescribed as and when required paracetamol and the protocol stated they could have eight doses in 24 hours rather than four doses (eight tablets). We raised this with the director who immediately changed it. We found another person had a protocol for prescribed paracetamol but this was not documented on their medicines administration record (MAR). We raised this and the nurse found a box of paracetamol had been received in January 2018 but it had been missed off the MAR. This had not been identified during audits. The nurse said, "[Person] will tell you they have had their tablets so it's down to the nurse's judgement of non-verbal communication and expression." The protocol stated the person would tell the nurse if they were in pain. This meant there was a risk the person hadn't received pain relief when they needed it.

NICE guidance for managing medicines in care homes state providers should have a process for handling and administering 'when required' medicines. This should take into account how staff identify when the person needs their 'when required' medicine, based on their capacity and information in their care plan. This information was lacking.

The recording of the time and dose of when required medicines was not always clear which presented a risk of overdose. The reverse of the medicine administration record (MAR) had not been used to record any specific detail as to why the medicine had been given. The nurse said, "It could be clearer." It had also been identified that the reasons people had refused to take their medicines were not always recorded. This meant people's symptoms may not have been monitored appropriately.

One person needed to take their medicines covertly, that is, hidden in food. Decisions had been made with the involvement of the GP, pharmacist and family in the person's best interest and this was recorded. It was not always clear how to administer the medicine, for example whether it was to be crushed or administered whole. It was acknowledged that further work was needed in relation to protocols.

We were told that no one self-administered their medicines, however one person was known to have over the counter medicines in their room. These over the counter medicines were stored in a bedside cabinet which was not secure. This person had capacity to do this, and staff said they were in the process of completing a risk assessment. At the time of the inspection there were no control measures in place to reduce, or assess the risks in relation to interactions with their prescribed medicines, the possibility of accidental overdose or the risk to others. Following our inspection we were advised that the medicines were no longer kept in the person's bedroom.

One person's allergies were not recorded consistently or accurately. One person's MAR front sheet stated they had no allergies to medicines but another document listed several medicines they were allergic to. This meant there was a risk people may have received medicines they were allergic to. There were inconsistencies with medicine care plans, some were in place and detailed clinical procedures for medicine administration, some were not in place and others were appropriately detailed. This meant people may not have been supported to take their medicines in the way they chose to.

Daily MAR chart checks had been introduced. On the ground floor daily checks had not been completed for nine days in February 2018 and on the first floor they had not been completed for 14 days in February 2018. There were three medicine signature lists, two of which were out of date.

A medicine audit had been completed by the director and assistant director during the inspection. This audit had not identified the concerns noted above, other than a lack of risk assessment for over the counter medicines being stored in an unlocked drawer.

The medicines optimisation team had also completed several audits within Stephenson Court and continued to find ongoing concerns, some of which are reflected above. Since the inspection the medicine optimisation team have conducted a further audit and have noted some improvements.

We spoke with the regional support manager about evacuation processes in relation to staffing levels and staff training. They advised us there were discrepancies in the fire policy and the training matrix as the fire policy stated fire drills should be four a year for night staff and two for the day staff however the training matrix stated all staff should have four drills a year. 77% of permanent staff had completed fire drills. We asked about fire drills for agency staff, especially as agency nurses were in charge of the building overnight. The regional support manager said, "There are currently nine agency care staff who had done a fire drill and one agency nurse." We raised concerns about how they would manage the situation if the alarms were sounded overnight. The regional support manager said, "We will do drills every day until everyone is covered, it will take a maximum of two weeks to complete". Since the inspection we have received confirmation that agency nurses have completed fire drills.

When we reviewed PEEPs (personal emergency evacuation plans) we looked at the building's fire zones. The regional support manager said, "We have different fire zones now, I'll get you the building plan." We saw fire zones had changed and asked if this had been shared with the staff. We were told it hadn't but it would be done during the huddle. The huddle was a daily meeting attended by the nurses and the heads of departments. We commented that the regional support manager needed to ensure the message was received by all staff. Permanent staff understood the fire procedure and the action they needed to take

however they said they were unaware of the change in fire zones which could have impacted on the safe evacuation of people in the event of an emergency.

We also found the PEEPs did not include information for people who used oxygen, in terms of this presenting with an increased risk due to being flammable.

The above concerns are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – safe care and treatment

During the last inspection there were mixed views about staffing levels. We found this was still the case. A relative explained they were concerned that agency staff didn't know their family member and communication was a concern. They also said they were hopeful that things would improve when permanent staff were in place. Another relative said, "There's a staff shortage but the staff are lovely and sociable." They added, "There's only two (staff) upstairs today but they do manage and don't moan." A visiting professional also said, "Finding staff can be an issue." Other relatives' comments included, "I don't know the staff and there's very little continuity of care, but they are trying to get on top of it" and "There are no keyworkers now, we did have a key person to go to as a named nurse who knew people well but we don't now."

Rotas showed there were four staff, including a nurse, on each floor until 2pm this then reduced to three staff, including a nurse on each floor until 8pm. Night shifts were covered by one nurse and three care staff. Staff were concerned that people's needs were not being taken into account when calculating the numbers of staff needed. They explained that nurses were included in the count but they were often busy with medicines, GP's or attending to clinical tasks. Staff explained that 16 people needed two staff to support them with various needs. One staff member said, "So on a late shift, when three staff work on each floor it means people often have to wait for their needs to be met."

One staff member said, "At times there's only been agency staff and one permanent carer on shift. Directing the agency staff is impacting on the support." They added, "It's disheartening." Staff also described days when they felt unable to take a lunch break until late afternoon as they wanted to make sure people's needs had been met. Other staff we spoke with confirmed this and said the nurses did not "Work the floor" as they were busy with nursing tasks. One staff member said, "There's been no improvement, we can't provide quality care. It's not a bad place but we need more staff."

We discussed staffing levels with the regional support manager and the director of operations and compliance. They offered assurances that staffing levels were based upon people's needs and advised that the staffing was above that identified by people's needs alone. This was confirmed when we looked at the dependency tool. On the third day of inspection they said they had now had two consecutive day shifts where no agency staff had been used. Overnight shifts were staffed using agency nurses and carers as there were only two permanent night carers employed. This was the case at the last inspection.

One staff member said, "We need the nurses to take charge, we need leadership and guidance. I love it here but we need someone to be in charge." A relative said, "We need more staff and less agency, I'm concerned about the attitude of some of the agency staff." A nurse said, "There are enough staff but they need more support, guidance and praise. We need to recruit more nurses and lots of supervision is needed but the consistency in agency staff is helping."

The above concerns were a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing.

Other comments about staffing levels were more positive. A relative said, "A few months ago you couldn't find staff to talk to if you wanted an update on how things were but now you can find people, there's more staff around although there's been big changes so it means getting to know staff." A staff member said, "Some things have got better. [Management team] are more hands on and seem to want the best for the home. It is hard work as a carer, there's so many new staff who don't know the home, and some staff who don't have much experience work alongside other new staff making it hard."

Current vacancies included 77 hours of night time nursing staff and 174 hours of care staff, all of which were currently being covered by the use of agency staff. Recruitment was ongoing and the director said, "It's not just about getting staff, it's about getting the right staff. Some have joined and already left as they weren't the right people." Staff were aware of the ongoing recruitment drive and that the provider was working to recruit more permanent staff to avoid the use of agency staff. The provider offered assurances that whilst recruitment was ongoing they were trying to ensure consistency with the same agency staff working at Stephenson Court.

Appropriate recruitment checks were in place which included an application form and interview, followed by the receipt of a minimum of two satisfactory references and a Disclosure and Barring Service Check (DBS). DBS checks are used to complete a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruitment decisions. Monthly checks of nurse registrations were completed and DBS checks were renewed every three years.

We spoke with people and visitors about whether they felt safe. One person said, "I feel quite safe here, I came here because my friend used to be here and I visited them. I'm quite happy." Another person said, "It's all okay here." A relative said, "I can walk away and relax and know [family member] is safe." They also said, "[Family member] can't use the nurse call but staff pop their head in." Staff were able to tell us how they kept people safe and how they would report any concerns. Safeguarding training was provided however, only 70% of staff had completed it.

Local authority organisational safeguarding meetings had been held since before the last inspection due to concerns in relation to the quality of the provision of care. This information had been shared during relatives' and residents' meetings and the provider had developed an action plan in response to the concerns.

A safeguarding log was in place which recorded a summary of the concern and a brief update on action taken.

The recording of accidents and incidents was completed as well as an analysis which had identified that 50% of falls had occurred overnight, however there was no information on any action taken to address this concern and mitigate or minimise the risk of this continued trend. It had been noted that during February 2018 only one fall had occurred.

Risk assessments were in place for areas of need such as bed rails, falls, choking and skin integrity. Recognised tools were used to assess people's nutrition and hydration risk.

Relevant safety checks of equipment such as hoists, window restrictors and fire doors were completed and in date. The gas safety check and electrical installation condition report were also valid. A new treatment room had been developed on the ground floor which had improved the cleanliness, organisation and storage of medicines. A nurse said, "It's a much nicer treatment room, we administer all medicines from here and upstairs is used as a storage room mostly at the minute. All trolleys are returned here after each

administration."

The environment was clean and there were no malodours. We spoke with the housekeeper who said, "There's more attention to care now, we have resident of the day and do a complete deep clean of the room. The nurse also evaluates care plans and maintenance do any jobs. It's easy to get around everyone as there are only 24 people. It's working well." They added, "We make sure we wash the mattresses and so on, there are no issues with equipment or products, I do the ordering so I ask what is needed, my priority for care is to make sure there's enough PPE." PPE is personal protective equipment such as disposable gloves and aprons.

We spoke with the management team about improvements and lessons learnt since the last inspection. The regional support manager said, "We discuss issues, mealtime audits are discussed with staff and we use the daily huddle for advice. Staff have done, 'React to Red' training in pressure care, staff awareness has increased and pressure care is discussed in the daily huddle." We asked about specific incidents that had occurred and if lessons had been learnt. We were told, "We transfer people as quickly as possible to comfortable seats, care staff have been told not to leave people and chair sensors and physio assessments have been requested."

The director told us, "We have changed the way we recruit staff, managers interviews are more competency based and we are also tracking applications for managers to be registered with the Commission. We have changed the contract for managers so they need to apply to be registered straight away." They explained that weekly manager reports were required for all homes operated by the Provider. They added that this had not been implemented at Stephenson Court as there was no regional manager in post but they were visiting the home on a weekly basis so were aware of any issues. A risk matrix had been introduced which documented compliance with key performance indications such as staffing, clinical concerns and CQC inspection outcomes. They also said they had done a lot of reflective practice on whether they had missed things and had tightened up on systems, processes and accountability.

There were mixed views from staff about improvements. One care worker said, "There's been no improvements, staffing hasn't improved, there's insufficient time to care for people and we are running everywhere, it's people's lives, we should have time to spend with people." Another staff member said, "Lots of hard work has been put in place, there is more management in place." We found there were ongoing concerns as detailed throughout the report.

Inadequate

Is the service effective?

Our findings

During the last inspection in October 2017 we found breaches in regulation in relation to the need for consent, staff training and support and a failure to meet people's nutrition and hydration needs.

During this inspection we found improvements had been made in relation to nutrition and hydration, however there were ongoing concerns in relation to consent and staff support.

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.

A log had been introduced which documented the dates DoLS applications were made and the outcome and expiry date. The regional support manager was able to explain any conditions which had been placed on the authorisation, for example in relation to nutritional support and people's safety.

During the last inspection we identified that one person had an authorised DoLS which had expired in January 2017 and no further application had been made until November 2017. There was no outcome and no evidence that a best interest assessor had completed any assessment. We reviewed care records and saw care plans which stated the person had an authorised DoLS in place which was not accurate. We raised this with the management team who said they would review it.

For another person an application had been made in May 2016 and there was no evidence of an assessment or authorisation so this had been resent in December 2017. A note was on their file to say they were awaiting a best interest assessment. A best interest decision was documented from December 2015 in relation to the use of bed rails however this had not been signed and there was no evidence that it had been reviewed.

These concerns were a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Consent

We saw some mental capacity assessments and best interest decisions had been made, particularly in relation to the administration of covert medicines.
Some improvements had been made with staff training however staff told us they did not feel they were appreciated and that they were not thanked when they had done a good job. We saw minutes of a staff

meeting signed as 26 February 2018 which thanked the staff for staying at Stephenson Court and for working hard. One staff member said, "I don't feel supported, I don't find the manager approachable." A newer member of staff said, "My first day was to shadow and have a run through with the girls, I did my moving and handling training then I was on shift properly." Other staff told us the director and assistant director were supportive but that they, "Hadn't had much to do with [regional support manager]." Another staff member said, "We don't get thanked, the carers are fantastic and bend over backwards, go above and beyond. We get no feedback, I haven't had a one to one, I was buddied for two days and did my training and was straight on the floor. There's a lack of appreciation, coaching and role modelling." We raised these concerns with the director of operations and compliance who explained that if staff needed more support it would be offered.

The regional support manager told us the expectation was that staff would attend a supervision meeting every two months and that appraisals would be completed by April 10th 2018. A supervision and appraisal matrix was in place. Of the staff who had been in post since before the last inspection only 25% had attended two supervisions since November 2017. 38% of staff had not had any supervision meetings. Three new staff had started in post in January 2018 and a further three in February 2018. One of the February 2018 new starters had received a supervision but the remaining five staff members had not had a supervision at the time of our inspection.

Induction plans were in place for permanent staff which included procedures such as walk arounds, absence, annual leave and safeguarding. There was no detail in relation to meeting people and reading care plans to understand people's needs. The provider gave reassurances that time was offered, however it was not recorded, therefore we could not be sure this had been implemented.

Agency profiles were in place which included checks of nurse registrations and DBS checks, alongside a summary of their areas of competency as assessed by the agency. Clinical supervisions had been introduced for nursing staff and some nurses from agencies where it was not provided by the agency. We did not see any evidence of induction having taken place for agency staff. The regional support manager said, "There haven't been any new agency staff since I started, the plan will be to induct any new agency staff."

We looked at the staff training matrix which identified which training the provider had assessed as mandatory. Not all staff had completed all the mandatory training, for example the completion statistics for bed rail management was 37.5%; mental capacity and deprivation of liberty safeguarding 64% and safeguarding 70%. 94% of staff had attended training in dementia awareness but no one had attended challenging behaviour training. Challenging behaviour training was seen as additional training by the provider however it had been raised during the last inspection by staff as not being provided. Higher compliance had been achieved for moving and handling training and medicines. We had been told by the provider in November 2017 that they would achieve 100% compliance by the end of December 2017 in areas such as dignity training, mental capacity and DoLS and person-centred care planning but this had not been achieved. On 8 March 2018 the overall completion rate for mandatory training was 81.8%. Staff told us there was lots of ELearning but they would benefit from more face to face training.

We asked the regional support manager about nurse competencies. They said, "The PEG nurse has been out but there's been no competency check of nurses for anything other than meds. There's planned training for PEG, venopuncture, catheter training has already been done." PEG is a way of feeding people directly into their stomach. We asked how they reassured themselves the nurses were competent to complete these tasks. They explained that nurses were bound by the NMC code of practice and they now had a nurse clinical lead. The director of operations and compliance sent us a list of the training that had been attended by the nursing staff. The list detailed that only one nurse had attended PEG training, other training attended included medicines, pressure care, and catheter care. Nurses had not had their competency assessed on a

regular basis in relation to various clinical tasks.

The above concerns were a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing.

We saw people's care was planned, however the documentation was not always accurate or reflective of people's current needs. All the staff we spoke to referenced that they had not had time to read care plans. This meant staff were not accessing care plans or risk assessments which should detail people's preferences for how they are supported as well as detail on how they need to be supported. It also meant they were not accessing guidance provided by healthcare professionals such as speech and language therapy and occupational therapists. Due to this we could not be sure care and support was being provided in a safe way in line with evidence-based guidance.

We raised this with the management team who said, "New staff have three learning days with a buddy care worker. Two half days which are supernumerary days to read care plans and policies." We commented that this wasn't a significant period of time if staff were new to care work and were told it could be reviewed if needed. They added, "Staff would never work alone until confident to do so and moving and handling training is completed before they start on shift. They wouldn't do any care provision until they are trained."

Hospital passports were being completed and it was proposed that they should be done as part of the 'resident of the day' routine. We saw some had already been completed however, questions with regards to whether or not people had DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation order), DoLS and EHCPs (Emergency Health Care Plans) were not always answered. This is vital information that needs to be available if people are transferring between services. Following the inspection the provider confirmed that this would be addressed and the required information would be made available if anyone was being transferred to hospital.

People had the involvement of health care professionals, such as GP, occupational therapy, district nurses and chiropody. Professional records were recorded in relation to visits however, they were not always followed up on. For example, a dressing had been applied by the district nurse and it was stated they would visit again in seven days to review but there was no information on the review, or if it happened.

The above concerns were a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

During the last inspection we recommended the provider research best practice in relation to the environment. No improvements had been made to the décor or to support people living with a dementia to orientate to the purpose of rooms. For example pictorial menus were not used, bathrooms were plain and there were no pictures so people could associate bathing with the room. Some rooms had the name of the person on the door but other people had nothing to support their recognition that it was their bedroom. We spoke with the management team who commented that they did not like memory boxes outside of people's room as they were not seen to be of benefit. They added that the staff adopt a more personal approach in supporting people.

One relative said, "The décor's a bit dowdy. They could do with modernising it up a bit, giving it a lick of paint, first impressions last." Another relative said, "The outdoor area needs some work, it's not particularly safe for people. The home needs to be refurbished."

The adaptation, design and decoration of the home did not fully meet people's needs, especially those

living with a dementia related condition. These concerns were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulations Activities) Regulations 2014 in relation to premises and equipment.

Some improvements had been made since the last inspection. The director explained that changes had been made to improve training. If staff did not achieve a score of 85% in their on-line training it was recommended that they repeated the course or a supervision was held to ensure stood understood the learning. The regional support manager said, "Once people have passed their probation and completed the care certificate they could complete a level two qualification in care, catering or business administration dependant on their role.

We also found improvements had been made to ensure people's nutrition and hydration needs were met. People mentioned that the food was nice, plentiful and that there was a choice. We spoke with people about their meal. One person said, "I enjoyed it, it was very nice but too much for me, I wasn't very hungry." A relative said, "The food is always nice, there's a good selection and I know the chef." We spoke with the chef who explained that they had the details of people's dietary requirements within a file and also on a whiteboard in the kitchen. The kitchen had a five star food safety rating and 89% of staff had attended food hygiene training. Fresh and dried foods were stored appropriately and fortified drinks were available for people.

Nutritional audits were used to identify if people were at risk due to weight loss or gain, it prompted staff to ensure care plans were in place if needed and documented the action taken, such as introducing fortified foods or food supplements. Referrals had been made to dieticians, speech and language therapy and GPs if staff were concerned about people's weight or nutrition.

Requires Improvement

Is the service caring?

Our findings

During the last inspection in October 2017 we found a breach in regulation as people were not treated with dignity and respect.

During this inspection we found ongoing concerns. One person said, "I consider myself safe although not well looked after because there's a shortage of staff. There's been no improvements recently because we've lost nurses and carers. It upsets me not having the same regular carers."

People told us there was a shortage of staff. People commented that there had been a lot of changes of staff and they did not know all the staff so they missed the 'chats' they used to have. One relative commented, "I'm concerned that the changes in staff have been unsettling for my [family member] who has complex needs." Another relative explained that they had raised a concern with a staff member about their family member's personal hygiene. They said things had improved but also said, "I put nail varnish on her because her nails are dirty."

We observed interactions and engagements with people during the inspection. During lunch time we noted there was a period of time where one care worker was in the dining room with seven people. Two people needed physical support to eat their meal so the member of staff was in a position where they stood to support each person and walked between them offering physical support. The people enjoyed their meal, and they were spoken to in a kind and caring way however the experience was not dignified as the staff member was not able to sit with each person and provide the one to one support they needed. We discussed this with the management team, including our observations that the staff member was in a difficult position as they either had to leave someone with no support, support both people simultaneously, or leave everyone to seek the support of another staff member.

On another occasion a relative sought the support of staff as someone needed support with their personal care needs whilst we were speaking with them and their relatives. They were unable to reach the nurse call and their relatives said they doubted the person had the capacity to use it, if it had been within their reach. The person needed two staff to support them with a transfer and they had to wait for a second member of staff by which time they had been incontinent which left them in an undignified situation with regards to personal care. We also observed on another occasion this person was in the lounge with no staff present for a period of about 15 minutes. They were not able to reach the nurse call bell and they told inspectors that they were not feeling too well. They said, "I'm a bit off colour, under the weather." We informed the staff and later saw that the person had received some as and when needed medicines. Staff were caring and supportive of the person and their family members when they arrived, and the treatment offered was appropriate.

We saw dirty plates from breakfast time were still in people's room just prior to lunch time. Some people and relatives commented to us, "Plates are left in the rooms until the next meal time." One person had a jug of water but no glass to use as their glass had milk in it.

Staff described how they worked as being, "Like a conveyor belt, we get people up, go to the dining room, do a transfer, people have lunch, we do transfers, they have tea, we do transfers, they get ready for bed." They added, "It's people's home at the end of the day and it shouldn't be like that. We feel we can't take breaks as the number of staff it leaves means they can't support people."

Our observations were that although care staff were kind, helpful and compassionate the provision of care was task focused as staff went from one task to the next without being able to spend quality time with people. We discussed our findings with the management team who explored the possibility that the concerns stemmed from a lack of direction and guidance on the floor rather than a lack of staff.

These concerns were an ongoing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to dignity and respect.

People and relatives felt they were supported by kind and caring staff. One person said, "98% of the permanent staff are wonderful and [staff name] is very good – a star!" Another person said, "The girls are very nice, kind and helpful." A relative said, "The staff are lovely, no one is ever nasty or grumpy." Another relative said, "I'm happy with how [family member] is looked after. The staff are friendly, they look after me and [family member], make sure we are alright." Another relative said, "There are some brilliant staff here, I'm pleased with the improvements."

We also asked about the quality of care that people received. One relative said, "Personal care was not what it used to be but it's got better, although when I visited the other day [family member] was still in bed at lunchtime. I know [family member] doesn't like getting up but they need to be encouraged." Another relative said, "The care was poor but there's starting to be an improvement." A third told us, "The basic care is fine, but people are isolated in their rooms."

We observed staff had a kind and caring approach with people however we could not be sure of the caring nature of the provider due to some of our observations and some of the comments made to us.

Requires Improvement

Is the service responsive?

Our findings

During the last inspection in October 2017 we found breaches in regulations. Care plans did not contain the information needed to support people safely and appropriately. They had not been reviewed regularly and were not updated in response to people's changing needs. They often contained contradictory information which placed people at risk of harm and inappropriate care.

During this inspection we found some improvements had been made however there were inconsistencies in the quality and accuracy of care plans. The provider shared an action plan with the commission after the last inspection which stated priority care plans would be rewritten to reflect people's needs and include person centred information. It also stated all other care plans would be brought up to date to reflect current needs. These actions were to be completed by 15 December 2017.

Short term care plans had been introduced for when people were unwell or when they had an infection, however they had not been evaluated and removed when people recovered. The care plan remained in care files almost a month after their infection had cleared. We also found discrepancies in relation to one person's mobility needs. The care plan identified how to support the person to transfer with the use of a stand aid hoist, however the monthly evaluations stated the hoist was only used when the person felt unable to stand. Care staff confirmed to us that they had not seen the care plan but they supported the person only occasionally by using the hoist. The monthly evaluation of their continence care plan also stated that they needed the support of two staff and the stand aid hoist if they did not feel confident to transfer with it. This was not detailed in the care plan.

We saw a care plan which stated a specific piece of equipment was used to support the person with chair transfers however following an occupational therapy assessment the equipment was not to be used. This information had not been used to update the care plan.

One care plan documented a specific amount of fluid the person should aim to drink however this was not always being monitored. This meant there was no accurate record of the amount of fluid the person had drunk which could have left them at risk of dehydration or infection. There was also reference to the need to record bowel movements using the Bristol Stool Chart. There were no charts in place but it had been recorded within daily notes.

A care plan for psychological and emotional needs prompted staff to 'encourage and prompt if I am confused.' An evaluation of the care plan on 4 March 2018 stated the person was prescribed a specific medicine should they be very agitated. The care plan itself did not provide specific detail with regards to when the medicines should be administered or how to monitor the impact. It did not describe how the person would present if agitated or how the staff should mitigate any risk or manage the situation, it did however refer staff to the plan the challenging behaviour team had developed which was in the care file.

NICE guidance for social care for older people with multiple long-term conditions quality statement five states, 'an older person's health and social care plan should be reviewed at least once a year, and whenever

there is a change in circumstances, to check that it is still meeting the person's needs.' Whilst care plans had been evaluated on a monthly basis, the evaluation process had not always identified that the care plan did not reflect people's current needs. This placed people at risk of receiving inappropriate care and support. Staff would need to read the care plan evaluations to be able to identify current needs. As there was a reliance on agency staff, and new staff were being recruited, it was imperative that care plans were accurate and up to date. We saw the handover records had much improved since the last inspection. They contained a detailed summary of people's key needs however they did not detail how to support the person.

There were different documents used to record people's needs. Some care plans included a tick box of risks in relation to people's needs such as falls and nutritional needs however we found this part of the care plan was not always completed even if risks had been identified. These care plans also included a section for a dependency score however this was not completed.

We spoke with the regional support manager about our findings in care plans. They said, "Yes, I would need to re-write them." They went on to say, "We haven't got around to doing them all yet." They added, "Any that were okay were left but [director] re-wrote those that weren't valid." They added, "We aren't auditing yet as such but are monitoring. [Director] did them quickly but they are not person centred so we are now re-writing them to make them person centred." They explained that two people's care records were fully up to date and complete. We reviewed these care records and found some discrepancies and gaps in information relating to people's needs.

They went on to say that the 'resident of the day' was completed which involved a review of care plans. It was noted on some of the daily huddle sheets who the resident of the day was but there was no further detail in relation to discussions held, actions required or taken. Nor was there detail on who was accountable. This process included the chef speaking to the person about the menu, a deep clean of their room, a discussion about activities and the evaluation of care plans. Evaluations were completed on a monthly basis, however there was no detail recorded about the content of other discussions held as part of resident of the day, such as feedback on menus or activities. Nor were the evaluations effective in triggering the writing of a new care plan when the persons needs had changed.

We discussed how people and their relatives were involved in making decisions about their care, support and treatment. Only one of the people we spoke with mentioned that they had been involved in developing their care plan and making decisions about their care. One relative said, "Someone had a discussion about care plans but I want to be involved in them. I haven't been so far." This view was shared by other relatives we spoke with.

The above concerns are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

We saw other care plans which were detailed, specific to the person and up to date. For example, in relation to assessing and monitoring mood, there were signs to observe for which needed to be reported to the nurse. There was also reference made to eliminating physical causes such as infection and constipation. The care plan also went on to describe possible ways to distract the person such as one to one time or spending time with their family.

We spoke with people and relatives about complaints. People had not raised formal comments but had shared concerns with us, and the provider in relation to staffing. One relative said, "Things are getting better. There were a few concerns a few months ago and we met with [regional support manager]. There's more stimulation for people now and more staff." They explained they had been concerned about hygiene needs

not being met and a lack of communication between staff and management, however they felt this had improved since the meeting. Another relative said, "I'm not really concerned about anything." A third told us, "I have no complaints whatsoever." They added, "If I have something to say, I say it. If I ask for anything they do it, there are no problems whatsoever."

One complaint had been documented and the complainant had received a response to say an investigation would be completed. Following the inspection it was confirmed that the director of operations and compliance had shared the outcome with the complainant, an apology had been offered, and this had been accepted.

At the last inspection we made a recommendation that the provider research meaningful activities for people living with a dementia. We found the activities available for people had improved.

People explained that there was a poster with activities on display. The activities co-ordinator said they tried to offer varied activities, including group activities, entertainers and one to one activities. A relative said, "There are more activities offered and people spend more time downstairs now, there was a virtual reality session and people were skiing and cycling they really enjoyed it." We saw a staff member had brought two therapy dogs to the home. People responded warmly and showed great affection for the dogs asking them to come for a fuss and chatting with them whilst they stroked them.

People said they didn't have any specific interests or hobbies and that they could join in activities if they chose to. One person said, "I can't get along to the activities because of my legs but I'm quite happy in my room." We observed activities taking place, such as musical instruments and singing which people thoroughly enjoyed. People also enjoyed the baking.

At the time of the inspection we were told that nobody was currently being supported at the end of their life. A policy titled, 'Dealing with the Death of a Client' was in place which detailed the procedures to follow after a person's passing. The 'Dying and Bereavement' policy detailed how people should be treated to ensure their dignity, privacy and comfort was maintained.

We saw some people had care plans in place in relation to their final wishes. One end of life care plan referenced that the person was 'under the protection of DoLS' however they did not have an authorised DoLS in place. We saw no evidence of any care plans in relation to people's spiritual or religious beliefs which may be important to at all times of their life.

Inadequate

Is the service well-led?

Our findings

During the last inspection in October 2017 we found breaches in regulation and identified widespread failings. Quality assurance and governance procedures had not been implemented or followed, and action had not been taken to address concerns. Audits had not been completed and there was a failure to ensure accurate and complete records were kept. The manager had been in post since November 2016 and had not registered with the Commission.

During this inspection we found a continued breach of regulation in relation to good governance.

The previous manager had left their post following the inspection. The director of operations and compliance told us that since the last inspection they had worked, alongside the assistant director of quality and compliance and the regional support manager to improve Stephenson Court. The director and assistant director had been at the home four days a week during November and December 2017 and since then had been at the home two days a week. A clinical lead/deputy manager had been recruited in January 2018 and external support from a consultant had been available during January 2018. Since the inspection it has been shared with the Commission that the deputy manager has left their position at Stephenson Court. A manager and a deputy manager have since been recruited.

The regional support manager had been based at the home since November 2017. We had been told they would be completing their application to be the registered manager. However, at the time of the inspection the regional support manager said, "I haven't had my DBS back yet." On day one of the inspection they went to the post office to submit their DBS application. We had not received a valid application to be the registered manager as it is not possible to do this without a valid DBS. Since the inspection we have received an application for the regional support manager to register with the Commission.

Throughout the inspection we were told there were 24 people resident across both floors and there were a mix of people needing nursing and residential care on each floor. On reviewing the 'register of service users' we noted this detailed 25 people. The administrator confirmed that the number of people resident at the time of the inspection was 25.

An action plan had been shared with the Commission following the last inspection. We discussed this with the director who commented that it had been produced in response to the initial organisational safeguarding meetings. We asked whether an action plan was in place to address the regulatory concerns identified at the last inspection. They said, "I didn't need one as I was here." They added, "I started a regulatory action plan on Saturday." We asked how they had monitored progress and ensured improvements were made. They said, "The safeguarding plan kept us focused, probably as I was here and there was constant communication and daily updates with [regional support manager]." We asked for a copy of the regulatory action plan to be shared with us. This was received on 13 March 2018.

A governance framework was in place but it was not dated. It stated the clinical governance forum had strengthened the quality assurance framework and strategy since August 2016. It went on to reference the

development of an annual audit and assessment framework. Despite asking, throughout the three days of inspection for any, and all information in relation to quality and governance we were not provided with a quality assurance framework or an annual audit and assessment framework. The governance framework detailed the meetings which should take place to support the framework but we did not see evidence of monthly regional and home manager governance meetings or monthly care home governance meetings. We saw one care governance meeting had taken place since the last inspection. Whilst the Governance Framework identified the members of a monthly clinical governance forum, which was supported by monthly regional and home manager governance meetings and monthly local care home governance meetings responsibilities and accountability arrangements were not clearly specified. The governance framework did state, '… it is the responsibility of everyone who works in the organisation to support the delivery of effective clinical governance and to ensure that systems put in place to facilitate it are followed in order to ensure the safe delivery and further development of high quality services.'

We discussed our findings in relation to governance and quality assurance with the director of operations and compliance and they confirmed that the quality assurance programme had not been fully implemented. Since the inspection the provider has further clarified the governance framework in relation to meetings that should be held. It is recommended that the provider review the terminology used in reference to the meeting structure to ensure consistency and understanding.

After the last inspection the provider informed us clinical governance meetings had been introduced and the first meeting was to be held on 21 November 2017. We asked for minutes of these meetings and were provided with minutes of care governance meetings, two of which had taken place prior to the last inspection, and a third which took place on 1 February 2018. The minutes did not detail any specific discussion in relation to the governance of Stephenson Court.

We were also informed that an internal quality assurance program had been implemented and completion was being overseen by the regional operations manager, however at the time of the inspection there was no regional operations manager in post so these arrangements has changed.
One home visit report had been completed by the director of operations and compliance since the last inspection, on 26 February 2018. This identified actions in relation to the external environment, the dining experience, a relative's concern that plates had not been removed from a family member's room, medicines management, actions in relation to two care records which had been reviewed, actions in relation to quality assurance, training and vacancies and recruitment. This report had been shared with the home manager on 2 March 2018 and detailed that the director of operations and compliance would monitor progress against the action on the 8 or 9 March 2018. Inspection site visits took place on 6, 7 and 8 March 2018 and there was no evidence that any actions had been implemented or who was accountable for completion and by when.

We spoke with the director again about quality assurance and audits. They said, "We have visits with actions not action plans, audits have action plans." They added, "The governance framework is being revised."

We asked about audits of care files and the director said, "There was no point in auditing at the start of the process due to them being that bad, we just needed to put it right and get them structured. We are now at the stage to audit and an audit tool will be sent out today." They also explained there had been a focus on practical support and getting buy in from the team.

Throughout the inspection concerns were noted by the inspection team that had not been identified by the provider. The medicine audit completed by the director and assistant director on day two of the inspection had a compliance score of 95%. Some actions had been identified in relation to the storage, return and recording of errors in relation to controlled medicines, and four people needing protocols for as and when

required medicines. However, it did not identify all the concerns noted during the inspection, nor did it identify the ongoing concerns identified by the medicines optimisation team. It had also been identified during a local authority monitoring visit that medicines audits should be more robust. Since the inspection the medicine optimisation team have audited and have noted some improvements.

Mealtime audits had been completed in January and February 2018 and had identified areas for improvement, such as no lead nurse in the room, tables not set appropriately and that it was generally a poor experience. Our observations found that people enjoyed the food, staff interactions were kind and table settings had improved. However when one staff member was in the dining area alone they walked between two people offering them both physical support with their meals.

We also found concerns in relation to staffing, staff support and supervision, fire safety and DoLS. Some improvements had been made in relation to care records and training however there were ongoing concerns identified which meant regulations had continued to be breached.

The above concerns are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance.

During the inspection we attended a planned team meeting with the staff. The regional support manager explained the inspection process and introduced the inspector to the staff. They asked us to leave the meeting for a short period of time so they could, "Have a word with the team." We respected this and returned to the meeting later. We were later told by care staff that whilst we were not present the regional support manager had requested that they did not share any negative information with us and that they remained positive and shared only improvements that had been made. We raised this with the director of operations and compliance. Following the inspection, it was explained that the regional support manager had had this discussion with the staff to raise moral and provide reassurance. The staff had been encouraged to share positive work and be proud of improvements that had been achieved as a team.

Management walk arounds had been introduced and were completed and documented by the regional support manager. They used their discretion to share findings from the walk arounds in the daily huddle to support improvements for example, the need for specific areas within the home to be cleaned. Staff told us spot checks had been completed at night by the director and assistant director. Staff commented, "They were really nice."

Some audits had been completed such as infection control, catering, nutrition, falls, nurse call bells and the dining experience. Action had been identified as part of the audit, and target dates were recorded and followed up on. Call bell audits had improved response times although staff had commented that they were often, "Told to answer a call bell when in the middle of doing something else."

Relatives told us they had been involved in meetings and had been kept up to date with actions following the last inspection. One relative said, "I get an invite to the meeting and we always get minutes." Another said, "[Director of operations and compliance] chairs the meetings and [regional support manager] is there but they only speak when asked a question." It's a productive meeting though, open and honest. It's straightforward and they seem to know what's needed." Minutes of meetings confirmed that relatives were provided with an overview of and update of action taken to address concerns and make improvements and people had the opportunity to ask questions.

Another relative said, "The best things are the good relationship with the staff, we have a laugh but they are good at their job. I have no rapport with the management. I know who [regional support manager] is, the

receptionist is lovely." They added, "I see the manager floating around all the time."

Staff told us they were kept up to date with the outcome of the last inspection and the discussions in the organisational safeguarding meetings. The housekeeper said, "The managers have kept us in the loop with what's happening, it's discussed in the huddle and team meetings." We saw minutes of team meetings from November 2017 and January and February 2018. The initial meeting shared the concerns following the last inspection and detailed what support would be in place to make improvements and it thanked staff for their ongoing commitment. The January 2018 meeting stated, 'Finally I would like to say thank you to all of you here today, thank you for staying, you obviously care about the residents here and we care about you, and we are trying our best for you all, and to try and turn this place around, not only for the residents and all the hard work you all have put into Stephenson Court so far.' The February 2018 meeting provided no update for staff, nor did it thank staff or identify any improvements that had been made, it focused on areas which needed further improvement such as staff responsibility in relation to infection control, increased sickness, use of mobile phones, bed rail checks not being completed, completing supplementary charts and ensuring drinks are offered to people and the completion of eLearning.

During the team meeting we observed the manager discussed the need to improve eLearning as the target of 85% achievement had not been met. Resident of the day was discussed as an opportunity to get everything up to date as there were only 24 people resident. An update on staffing and recruitment was shared as well as care governance and an update on people at risk due to weight loss, accidents and infections.

Care staff raised concerns about staffing levels and the regional support manager explained that it was hard and that nurses should be helping with care tasks and staffing issues and concerns would be discussed in daily huddles. We did not observe this happened in the huddle we attended.

There were mixed views about improvements since the last inspection. The administrator said, "There's been big changes, the treatment room, the daily huddle, training, care plans are in place and there's new paperwork." Staff were able to explain the purpose of the daily huddle. One staff member who attended it said, "It means if there's an issue we can talk about it and resolve it. We get an overall picture of people so we know what needs doing such as the deep cleans."

Most of the concerns raised by people, relatives and staff were about staffing levels, the lack of consistent staff and the use of agency staff, particularly at night. People shared their concerns that they did not know the staff and likewise that the staff did not know them. Relatives were similarly concerned about the lack of continuity of care and the lack of knowledge staff had about their family member or how to communicate with them. The management team acknowledged the concerns and a recruitment campaign was ongoing. They also discussed ideas for sharing information in relation to staffing with people, for example using a 'welcome board' to let everyone know when new staff were in post.

Relatives did acknowledge that there had been some small improvements in care and some stability in staffing noted over the few weeks prior to the inspection.

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 15 HSCA RA Regulations 2014 Premises and equipment The adaptation, design and decoration of the home did not fully meet the needs of people with a dementia related condition. Regulation 15 (1)(c).

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure service users were treated with dignity and respect. Regulation 10(1)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to ensure care and treatment was provided with the consent of the relevant person. There was a failure to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure the proper and safe management of medicines. There was a failure to do all that was reasonably practicable to assess and mitigate risks to the health and safety of service users of receiving care and treatment, including ensuring staff had the

	appropriate competence to evacuate people in the event of an emergency. Regulation 12(2)(g); 12(2)(a); 12(2)(b)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems and processes were established and operated effectively to ensure compliance. There was a failure to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. Including the quality of the experience of service users in receiving those services. There was a failure to ensure accurate, complete and contemporaneous records in respect of each service users. Regulation 17(1); 17(2)(a); 17(2)(c)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a continued failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet peoples needs. There was a continued failure to ensure staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform 18(1); (2)(a)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.