

KRG Care Homes Limited

Lound Hall

Inspection report

Jay Lane
Lound
Lowestoft
Suffolk
NR32 5LH

Date of inspection visit:
25 January 2017
30 January 2017

Date of publication:
08 May 2017

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

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

Before the inspection, feedback we had received from people using the service, their relatives, advocates and professionals, which raised concerns over the leadership and governance of the service. They told us the systems in place to monitor the quality of the service people received were not effective enough to independently identify and address shortfalls. Where people told us they felt the service had not effectively listened, and responded to their concerns in a timely manner, it had impacted on their confidence in the ability of the management to address them. This had resulted in the service being required to put in 'action' plans to reduce risk to people living in the service, and being given support to improve in areas including care planning and infection control. This had led to improvements in these areas. Work was being undertaken by the provider to gain people's confidence back. The provider told us they were in the process of recruiting to a new clinical lead to oversee the quality of the nursing being provided. Relatives spoke about feeling more reassured by a more visible presence of the provider's representative. However, further work was still needed to instil confidence in the daily management of the service, as part of driving continuous improvement.

People told us they felt safe living in Lound Hall, and spoke about the improvements they had seen in the standard of cleanliness within the service.

We found improvements were needed in the management of medicines and staffing levels. This is to ensure people received their medicines as prescribed, and that there were enough staff to monitor, support and respond to people's individual needs.

Staff received training in core skills to support them providing a safe service. However some infection control and health and safety training needed to be embedded in practice. We found shortfalls in staff's knowledge of supporting people living with dementia; we have made recommendations around training to support staff in gaining these skills.

People told us they did not have enough access to stimulating activities, linked to their individual interests and needs, to occupy their time. Where people were spending long periods of time without quality interaction, this put people at risk of becoming socially isolated.

People were not always supported to have maximum choice and control of their lives and to ensure staff supported them in the least restrictive way possible; the policies and systems in the service did not always support this practice. There was a lack of forums to support people in voicing their views and experiences, and be influential in driving improvements.

Improvements were required to ensure all staff's interactions with people were caring and empowering so all people feel valued. This included looking how routines can be changed to support the person, not the other way round; more supportive of person centred care. Systems had been put in place to check the contents of people's care plans were accurate and reflected their needs and preferences. This needed to be developed further, to ensure the person and all staff involved in their care are aware of the contents, so any missing information / inaccuracies are quickly identified.

People complimented the quality of the food. However, we found people were not always supported to ensure that they had enough food and fluid to support their health needs. Records were incomplete and not assessed to make sure that people had enough to eat and drink. Where people of low weight turned down food, or had a low appetite, this was not always being effectively managed. This included offering nutritious, high caloric snacks in-between meals, or as an alternative where people had declined. This put people at risk of losing, or not maintaining their weight gain. We made a recommendation to support staff in improving people's meal time experiences, especially for people living with dementia.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this 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?

Requires Improvement ●

The service was not consistently safe.

Staffing levels were not always sufficient to meet people's needs.

People were not always receiving their medicines as prescribed.

Improvements were needed to ensure staff were consistently monitoring for any potential risks during care delivery which could impact on people's welfare.

Is the service effective?

Requires Improvement ●

The service was not consistently effective

Staff received training but they did not always put into practice what they had learnt. We found shortfalls in staff's knowledge of supporting people living with dementia.

Not all people were being effectively monitored and supported by staff to ensure they were given enough to eat and drink to support their health and welfare.

People were supported to maintain good health and had access to appropriate services which ensured they received on-going healthcare support.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Improvements were needed to ensure all staff's interactions were caring and compassionate, so all people felt listened to and valued.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

Improvements were needed to ensure all people had access to stimulating occupation / activities, linked to latest research, which met their individual needs.

Concerns and complaints were not always acted on and responded to in a timely manner and used to learn from, as part of driving continual improvement within the service.

Is the service well-led?

The service was not consistently well led.

Improvements were needed in the quality monitoring systems to ensure they are robust enough to independently identify and address shortfalls, and embedded to drive continual improvements.

Improvements were needed in the leadership of the service. This is to ensure they have good oversight of the service to be able to address concerns before they escalate / impact on the quality of people's care.

Requires Improvement 

Lound Hall

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 25 and 30 January 2017 and was unannounced. The inspection team consisted of three inspectors, one of which was a pharmacist inspector and an expert by experience on the first day, and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from relatives, and stakeholders for example the local authority, clinical commissioning group, safeguarding and Health Watch.

We observed the care and support provided to people and the interaction between staff and people throughout our inspection. 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.

As part of this inspection we gained feedback from nine people using the service, five relatives, a visitor, an advocate and six professionals; specialist nurses, paramedics and social care. We spent time with the registered manager and seven members of staff, which included the deputy manager, nurses, senior carer, carers, catering and administration staff.

We saw records relating to seven people's care, three staff files, staff duty rosters and records relating to the management of the service including recruitment records, training records and systems for monitoring the quality of the service.

Is the service safe?

Our findings

Improvements were required in the management of medicines. Records showed that people were not always receiving their medicines as prescribed. We noted some record-keeping discrepancies including records that showed where people had received incorrect doses of anticoagulant medicine placing their health and welfare at risk of harm. The service had not identified that one person's medicine that had recently been stopped by their prescriber; was still being administered by staff.

A relative told us, "Medication comes at the expected times, they put in their eye drops alright, they take their time with [person], they're good with them." However, records showed that a person had not received their eye drops for seven days. We also found that there were other medicines that had not been obtained in time which resulted in people not being given them as prescribed.

Records showed that people had not always received medicines that were required to be taken for external application, such as prescribed creams. As the service had not recently carried out full audits of medicines this hadn't been identified as a shortfall. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to administer some of these medicines; however, this information was not available for all medicines to be given this way. In addition, more detail was required for medicines prescribed this way particularly for those people that were prescribed using more complex pain-relief strategies to ensure they were used appropriately and consistently. Pain assessment tools were not being used for people prescribed pain-relief medicines and who were unable to communicate about their pain-relief requirements to enable staff to give them their medicines consistently and appropriately.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

People's medicines records provided information to confirm their identity and any known allergies/medicine sensitivities which could impact on their safety. Also information on the level of assistance people needed to take their medication was available. One person told us that their medicines were, "Always given by one of the nurses, oh yes they stay with me while I take it."

We found that there was no system in place to determine the number of staff required to care for people using the service. This impacted on staff's ability to flexibly monitor people's safety, personal and emotional needs.

There was no readily available information to confirm how many people had a diagnosis of dementia, required the support of two staff, or whose complex needs could have an impact on the number of staff required. This information was needed to assist in calculating staffing levels. The registered manager told us the day time staffing levels normally consisted of two nurses, one senior carer and six carers in the morning. Records showed from 02 to 28 January 2017, this staffing number had been achieved on 16 of the 27 days.

The views from people and relatives on the staffing levels varied, depending on their individual needs and if

the service was working to the numbers we had been told. One person told us , "There's always somebody about." Another person said, "You always get an answer (call bell) but when you need two (staff to hoist) it's a problem." Whilst waiting for a second carer to assist a person to reposition who was in discomfort, a relative told us, "In the meantime a carer helped me lift [person] to relieve the pressure." Another relative told us that the staffing levels, "Last weekend were terrible," which had resulted in staff being rushed and forgetting to ensure, "Little things," were done, such as including ensuring people had their hearing aid and teeth in.

Staff said when the planned staffing levels were being maintained there were enough staff, but that when they, were reduced, they felt under pressure. One staff member said it was, "Really, really hard when [staff] call in sick, we struggle, the other day three people called in sick." Another staff member felt more could be done to prevent the situation, "If you had more [staff] to begin with," they wouldn't be affected so much by staff calling in sick. For example, "Yesterday five" care staff were on duty. Although they felt they were still able to meet people's needs, staff felt, "Pushed," and it impacted on people's care because it took longer to, "Get around."

On the first day of the inspection there was a full complement of staff on duty. Although staff responded to call bells, there were insufficient staff to support people who remained in their bedroom, or to have a visible presence in the communal areas. Discussions with two people showed that they had been waiting long periods of time for staff to assist them to get up, or with their personal needs. One person had missed being able to get up and sit in the conservatory for the morning. The second said they had been waiting all day for support with their mouth care but staff were, "Too busy." Having asked staff again, they had informed them, "It was too close to tea [time]." It was only when we pointed this out to staff action was taken.

With no staff members present in the lounge, a person who required assistance when walking started mobilising independently. This resulted in another person pressing the emergency call bell, which a Nurse and two care staff responded to immediately. One person commented, "If [person] gets up and wanders one of us calls the alarm." Although this reduced the risk to that person, with no visible presence in the lounge, or sensors in use to alert staff to a person moving, this put the responsibility onto other people and visitors in monitoring the safety of others. It further demonstrated that there were not enough staff deployed in the service to meet people's needs in a safe and timely manner.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Improvements were needed in the service's recruitment processes. Not all of the recruitment files that we saw showed that full checks had been undertaken prior to staff commencing employment. For example, one person was employed without two references from previous employment being sought. A staff member said that the priority was ensuring they had a DBS, rather than references in place before they started. The registered manager was unaware that the staff member had started work without the paperwork being in place. They said a more robust check list would be put in place to prevent it happening again.

One person commented, "I always feel safe here, definitely." Records showed that safeguarding concerns had been investigated by the lead agency, responsible for investigating. Where shortfalls in practice had been identified, action was / had been taken to address these. For example, the call bell system was in the process of being upgraded to ensure it was fit for purpose and met people's individual needs. One staff member felt the call system was now much better where people's handsets benefited from improved touch sensors.

Staff received safeguarding training as part of their induction to ensure they had awareness of signs to look

for, and what action to take if they had concerns about a person's welfare. A staff member said the training had included reading about the different types of abuse that can occur, and then being, "Asked questions," to test their knowledge and relate it to practice. Another staff member told us they, "Would report," any concerns straight away to the leadership team. If they felt their concerns were not acted on, they were aware of the external agencies they could contact. Records showed that the local safeguarding team had also provided refresher training for staff to keep their knowledge updated.

Improvements were required in the management of risk. We found some detailed risk assessments but not all risks that could be associated with a person's daily activities were being risk assessed. This included where applicable, people at risk of choking. Staff awareness of potential risks to people needed to be embedded in their everyday practice. This is to ensure they are constantly monitoring for any potential risks, and taking appropriate action. For example, until we pointed it out, staff had not noticed where protectors fitted to people's bedrails to prevent the risk of bruising or limbs getting stuck had not been secured. This meant they could easily slide off, and posed a risk to people's safety. This had not been considered by staff.

A relative praised the domestic staff, "I wouldn't fault any of them." In August 2016 an infection control audit was undertaken by the external health professionals who identified shortfalls in practice. The provider put an action plan in place to address the concerns raised. We found that although cleaning schedules and audit checks had been put in place, good infection control was still not embedded in staff's practice. Further work was needed in staff identifying and taking action to address any unclean equipment, or potential breeding areas for bacteria. For example, we saw a soiled toilet brush and 'slipper' pan. Two used bars of soap and a 'body puff' had been left in the shared bathroom. This put the items at risk of being used by others and the potential risk of infections being passed from person to person.

Is the service effective?

Our findings

Improvements were required in monitoring people's nutritional needs. Where people had been assessed at risk of malnutrition, staff needed to be more effective in checking and encouraging people to eat and drink to ensure their health and welfare. This included keeping accurate records to support staff in knowing how much, or how little a person had to eat and drink. Staff also needed to be more proactive in using high calorie foods to promote weight gain, rather than just relying on prescribed food supplements.

A member of staff told us they had recently completed a course on nutrition. Their responses to our questions showed their awareness of using, "High calorie snacks," but it was not being embedded in practice. One person who said they had, "Lost a lot of weight," told us that they weren't given additional snacks.. Records showed no extra snacks, apart from the same, were offered (biscuits) to others with their hot drinks between meals. Fresh fruit was not made available during the day for people to help themselves, or prepared and given to people to snack upon. Instead staff said people could have fruit as a menu choice, or on request. This relied on the person's capacity to ask staff. This was further demonstrated by a person who had capacity, who told us they were given plenty to eat and drink, "All we have to do is ask."

We found staff lacked an awareness, of how a person's mental / or physical frailty impacted on their ability to ask for / have access to nutritious snacks and drinks. This put the person at potential risk of not being given sufficient food to meet their needs. Therefore this put them at risk of losing weight, or being unable to maintain any weight gain. For example where staff recorded a person had 'declined' or eaten very little of their meal, and were severely underweight, no further action had been taken. Records showed where staff had two opportunities later in the evening when they had been providing care to offer the person a snack, but hadn't. Their next food intake being breakfast the next morning, which their relative pointed out, was, "Too long." This showed a lack of initiative being used by staff in promoting a 'food first' approach to boost calorie intake to maintain and support weight gain. This put people at potential risk of losing / not maintaining a healthy weight and going for long periods without food.

People told us they enjoyed the quality of the food. One person told us, "I couldn't get better [food] in a hotel, they come with a couple of choices, but you can have whatever you want." Another person who described the food as, "Excellent...first class," told us they were offered enough variety, including a roast option on a Sunday and fish on a Friday, "I'm not a tremendous fish lover but I do like scampi and they do that for me if I ask." A relative told us that, "There's a menu in [person's] room, four weeks dinners and desserts, that's good really." They said that this was quite new, and enabled relatives to advocate on the person's behalf, by informing staff of, "Things [person] mustn't have or didn't like."

The service benefited from having an 'in-house' training officer. They told us how they monitored people's range of health needs, and where needed printed off information sheets to support staff's learning. They showed us the systems in place to ensure all new staff gained an insight into their role and to support them in getting to know the individual routines and preferences of the people they would be supporting. New care workers were working towards gaining their care certificate. This is a recognised set of standards that care workers should be working to. A new staff member said that they had, "Learnt quite a bit," and described the

in-house trainer as, "Really good." They felt the mix of face to face training, E-learning, work books and 'shadow shifts' supported their training needs.

However, feedback we received from people, relatives and professionals showed that further work was needed to ensure that the 'depth' and 'range' of training met the range of people's needs who were accommodated in the service. The quality and effectiveness of the care people received varied. This was because it was dependant on the person's individual needs, and staff's knowledge and skills to be able to support them. For example, one person told us that they felt confident when staff supported them to transfer, "I have to be hoisted, I'm always reassured by staff that it is no trouble...In all honesty I can't fault," the effectiveness of the support they received from staff. Another person who described staff as, "Very good," felt they had the skills and knowledge to meet their individual needs.

A relative told us that the service was, "Not dementia experienced as advertised," and the staff's lack of understanding in how dementia impacted on a person's ability to communicate impacted on them being able to effectively meet their needs. This was our observation. Professionals provided examples where the lack of having a 'role model' for the Nurses, with the skills and knowledge to monitor the quality of clinical and care practice had impacted on not meeting people's clinical needs effectively. For example, shortfalls in the management of eye drop regime, catheter care and infection control procedures, putting people at potential risk of infections; had been picked up during visits from professionals following complaints, not by the management. To address this, the provider was in the process of recruiting to the post of Clinical Lead Nurse and Senior Nurse. The aim of the new nursing structure would be for them to work closely together with the leadership team to drive continuous improvement in the learning and development of nursing provision.

We recommend that the service uses a reputable source to gain further insight into the skills needed to provide effective dementia care. For example National Institute for Care Excellence (NICE) guidance for supporting people to live well with dementia.

The Mental Capacity Act (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 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 found that the service had submitted DoLS applications to the appropriate supervisory body. However, the leadership was not aware of their responsibilities in notifying the Commission about DoLS authorisations as part of monitoring to ensure any conditions and recommendations were met. Once pointed out, they took action and submitted the appropriate notification.

A staff member spoke about the recent MCA training they had completed. They were able to relate the training to practice, providing examples; linked to a person they supported and their capacity to make decisions. This included those they could make on a daily basis, and when they may need the involvement of family and health professionals to make a 'best interest' decision to ensure their health and welfare. For example if they were not taking their medicines, to enable them to give it 'covertly'.

People told us they were supported to access healthcare services. Action was taken during the inspection to ensure a person's health and welfare following a fall. The visiting health professional told us that calling them out had been appropriate, linked to the person's injury. They were complimentary about the support they had been given by staff, "They seem to know the residents well. They [people] seem very well looked after."

Is the service caring?

Our findings

Improvements were required to ensure all staff's interactions with people were caring and empowering so people felt valued.

Where staff engaged with people they showed signs of well-being; smiling, chatting and joking with staff. One person told us, "I get on well with staff," whilst another person commented that, "Well all the staff here are wonderful, all of them are friendly...I can sum up the staff, they all make me feel special, yes they do listen." Examples they gave of, "Going the extra mile," included, repositioning their cushion to ensure their comfort, and on their birthday, staff singing, "Happy Birthday," and decorating their bedroom. A relative remarked, "They're [staff] like friends, you can chat with them."

A staff member visited a person in their bedroom and we saw that they interacted in a caring and reassuring manner. They were aware due to the person's personal circumstances they were feeling a little, "Down." They leant over the person's bed in order to make eye contact and proceeded to listen intently, responding to the person in a compassionate and caring manner. The person described the staff that supported them as being, "Very helpful, very kind and thoughtful." At lunch time another person was supported by a staff member in a patient and caring manner as they assisted them with their meal.

However some staff didn't show the same level of caring involvement with people, supportive of developing caring relationships where people felt valued. One person commented, "Some of them [staff] are friendly, some of them have got a little twig on them, I don't let it get me down." A relative said they had observed that staff, "Walk in, do the job [personal care] without talking to," the person. Another person told us, "The carers don't have time to sit and chat with you, it's important to me." When the staff member brought them in a drink and left, they remarked, "That's about the limit...I think people get better if they see people twice a week." Where a person was new to the service, we saw they were left on their own with no interaction for most of the day. At lunch time, due to the task led approach, staff missed the opportunity to socially interact to make it an enjoyable experience for people in the dining room.

We found the service could be more proactive in supporting people, in voicing their views and making decisions. For example, one person told us that the timing of their medicines spoilt their meal experience, "I complained once to [named nurse]," and was informed, "You have to have the medication with meals, I find it annoying and I'm good at taking them." This type of response was more a statement, leaving the person out of the decision making, as it lacked any proper explanation or compromise.

The system used for ordering meal choices, which was done a day in advance, suited the needs of the people who could understand what staff were asking them, and could remember their meal choices. One person said staff, "Ask me what I want for tomorrow about now (11.15am) it doesn't bother me." However, this system was not so supportive for people with impaired memory, or living with dementia who may not understand what they were being asked. When asked what they had chosen for lunch, a person replied, "I can't remember what I ordered." They had no idea what was on the menu, there were no menus on the tables or signage in the dining area to act as a prompt. We did not see sample plates being used, so a person

could see / smell / taste what was on offer at the time, which could trigger a memory and support their decision making.

We found the dining experience could be improved upon to make it more supportive and welcoming place for people to dine and socialise. Tables were not laid, there was no background music or interaction between people, and any interaction from staff was task led. Where one person sat with another person who didn't interact with them, we saw how they tried, and failed, to instigate conversation with the person they were sat with.

We recommend that the service consults with people and uses a reputable source to support them in improving the meal time experiences. For example the Social Care Institute for Excellence and the National Institute for Health and Clinical Excellence.

The leadership team were putting together 'Dignity' boards, linked to their values, as part of raising staff's awareness and people's right to be supported in a respectful and dignified way. By promoting awareness, the leadership team were looking to support staff in reflecting on their own practice, and areas for development as part of driving improvements in this area.

People felt that staff respected their privacy and dignity. One person gave examples by ensuring their dignity during personal care, "They cover me up," and staff being respectful that their bedroom was their private space, "They treat it as my room, knock on the door." We saw signs hung on people's bedroom doors, alerting people that they were receiving care. A relative who visited regularly said, "Their [staff] attitude is good, they always knock, they put a sign on the door today saying 'personal care', I've never seen that before, normally I don't know if they're in the room dealing with [person]. I hope they continue with that practice."

At lunch time a staff member, aware that some people may want to protect their clothing from food debris, was asking people individually, "Would you like an apron on?" to protect their clothing, and waited for their response. One person replied, "Yes please you know I am a mucky pup."

Is the service responsive?

Our findings

People were not always receiving personalised care which was responsive to their needs. One person told us, "There could be a few more activities, I do get bored." We found where people were left for long periods without meaningful interaction; this put them at risk of being socially isolated. A relative told us especially for people living with dementia, "Needs encouragement to socialise and not sit alone all day." Where staff were not given sufficient time to interact, and lacked awareness of how a person's diagnosis affected the quality of their life; it impacted on staff's ability to engage with people, and provide person centred care.

Staff told us they did not have time to read people's care plans and there was a reliance on information being given verbally. One staff member commented that the registered manager had told them that they should be reading the care plans but they, "Don't get the time."

Records and discussions with the registered manager and staff, showed the work that had been undertaken during the last few months in improving people's care planning records. This was in response to concerns by commissioners of care following the outcome of complaints, where people's care plans did not provide sufficient, detailed information to support safe, person centred care. However improvements were still needed in the quality, consistency and content of people's care records. This was to ensure staff were provided with clear guidance on how a person's medical, physical and mental health condition impacts on their ability, health and well-being and how their needs and preferences were being met.

For example, feedback we had from relatives of people living with dementia reflected what we saw and read in their care records. More information was required about the person prior to their diagnosis about their life, to the present time, to support staff in gaining an understanding of how dementia has / is impacting on the person's life and abilities. How past memories / incidents / events could impact negatively or positively on their behaviour now. This knowledge would enable staff to put strategies in place to enhance their quality of life and reduce anxiety. This included supporting people with dementia related behaviours.

Where staff had completed a person's behavioural chart, they had described them as being, "Very agitated and aggressive." However there was no risk assessment or guidance for staff on how to support the person during their distress. . There was no information about if lessons could be learnt through staff's own practice, including how the environment, lack of stimulation and meaningful communication, could have triggered the behaviour. We saw the person had spent the day walking around and had become more anxious as it got darker. Although staff were aware that this was part of the person's usual pattern, we saw no effective action being taken to respond to their needs. With staff focused on their tasks, one of the inspection team spent time with the person, providing reassurance. No action was taken by staff on both days of the inspection, to draw the curtains when it became dark, in case the dark shadows seen through the window were an attributing factor to the person's anxiety.

We found people who were spending long periods of time without meaningful conversations or occupation, were at risk of becoming socially isolated. One person told us, "There's not much," activities going on, "We play bingo, skittles and we had a quiz the other day, perhaps two things a week, but only four or five people

join in." Care staff told us their availability to support people through one to one and group activities were dependant on the staffing levels. The activities coordinator had been absent for a while, no-one had been rostered to cover their work. Staff rosters for 25 December 2016 to 4 February 2017 confirmed no activity hours had been allocated.

We did not observe any activities going on, or see people living with dementia being supported through objects of interest to stimulate memories and senses, such as 'fiddle blankets and cushions.' When we asked a member of staff of how they supported people living with dementia to be socially simulated they replied, "Most end of life care...most like music."

The 'My Story' section of a person's care records provided some aspects of the person's childhood, but nothing about their working life. Where it listed interests such as watching television and reading, there were no specific examples of what programmes they liked.

The activity records used to record social interaction, were not always filled in, and often showed that people declined, but it was not made clear why. We looked at three people's daily 'activity' record sheets, two living with dementia, dated 18 to 28 January 2017. There were gaps, where days hadn't been completed. Out of the three, one person, on one day had been 'initialled' by staff as participating 'in daily' scheduled activity. Nothing further on the type of activity and level of engagement. The only other social interaction mentioned was receiving visits from family / friends or sitting in their bedroom watching television / listening to music. Discussions with staff showed they wanted to spend more time with people, but when busy, prioritised on meeting people's personal care needs.

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

We found improvements were needed in how the service listened, recorded, responded to and learnt from people's experiences and concerns.

People, their relatives and professionals were not always confident that their concerns and complaints would be dealt with in an effective manner. Relatives provided examples of where they had raised complaints with the management, who they felt had been slow to respond and / or take effective action to prevent it happening again. Two relatives told us they had, "Lost confidence," in the complaints system.

Information we held on the service, identified where the leadership had not been responsive in dealing with people's complaints effectively. Especially where they had not taken a 'lessons learnt approach', by taking action to prevent a reoccurrence of the same or similar concern to happen again. However, we also received feedback during the inspection that showed the situation was starting to improve, since the provider's representative had become more actively involved. This included completing a detailed investigation and responding to the complainant.

We looked at the system the service had for recording complaints and actions taken. We drew to the registered manager's attention that the system for recording complaints was confusing. It did not support the registered manager in identifying how many complaints they had received, and time lines to show action taken. They told us they would take action to address this.

Is the service well-led?

Our findings

We found that the management and leadership of the service did not always understand the principles of good quality assurance and oversight to drive improvements within the service. This included learning from complaints and safeguarding and establishing quality assurance systems which were effective enough to monitor, identify and address shortfalls to ensure all people received good quality care.

Feedback from people, relatives and professionals identified concerns where they had lacked confidence in the skills and reactivity of the provider and management team. One person told us, "I wouldn't say [Registered manager] inspires me and I can't be sure what she says she'll do will happen...tends to say yes, but then things just seem to get left, so their positive response doesn't mean anything after a while."

A professional told us that the management, "Appears powerless to change staff practice." This impacted on the care, safety and experiences of people using the service and their relatives. They felt that there was not sufficient oversight of the daily management of the service.

Feedback from relatives, staff, professionals, and our own observation, showed that the registered manager could be more proactive in having a visible presence in the service. This would enable them to gain a better oversight of people's needs, daily routines and the quality of care people were receiving. They felt that their lack of awareness of what 'was going on' was further evidenced by not being able to respond to their questions effectively, or supportive of bringing about changes of staff practice. Examples given, including seeing and gaining feedback on how low staffing levels, linked to sickness, impacted on staff being able to provide quality care.

Relatives shared their experiences and frustrations when dealing with the leadership team and getting them to act on their concerns in a timely manner. One relative told us it had taken months and, "Several meetings," before finally addressing their concerns. They spoke about seeing more of the provider's representative lately, "I think things are getting better, he normally comes in on a Wednesday and makes a point of saying hello, there's more chance now of getting things sorted out. I think his influence is being felt for the better, we feel more at ease with our problems."

Following the outcome of complaint and safeguarding investigations conducted by outside agencies, professionals spoke of their frustration where, "Resolution is always slow and sometimes doesn't happen." As records showed, this was despite being given detailed verbal and written feedback on areas requiring improvement, and the provider's committed responses during meetings. They felt the lack of having a visible, knowledgeable, cohesive leadership team in the service, impacted on the number of concerns being escalated to external agencies.

We found the leadership and culture of the service did not encourage or support staff, to recognise where improvements were needed, take prompt action and ensure any changes are embedded in staff's practice. For example on the first day of our inspection we spoke with the registered manager after we found unsecured bedrail protectors, the risk of them slipping off made them unfit for purpose. On our return five

days later, they told us the situation had been addressed, but it hadn't been as we found the same situation. Staff practice was task based and there was scope to improve the quality of care people experienced. Best practice was not being explored to influence how care was being delivered. For example effective engagement with people living with dementia, providing mental stimulation and activity and ensuring that risks linked to poor nutrition were addressed proactively. Records showed that our observations reflected those identified by visiting professionals, and reported back to the registered manager in July 2016; but had not been actioned.

Because of this we were not assured that the service had a consistent approach to governance that ensured the quality of the care they received.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were required to ensure the audits and checks in place, were regular and robust enough to monitor the quality of service and drive continuous improvements. For example, although we saw people's care records were being audited, with a list of any areas needed to be updated / amended and given timescales. We found there were no effective systems in place to monitor, on a daily/shift basis to ensure that people's records were being completed accurately and legibly. Where staff were monitoring a person's hydration, the intake for three days had been entered on the same sheet. This rendered it unfit for purpose and could impact on staff not being able to monitor the person's health and well-being.

Improvements were needed in how the service supported people using and working for the service as well as stakeholders, in developing a more open culture and be influential in driving improvements. One person told us, "No they don't ask me what I think about the service." A relative commented, "There's no relatives or residents' meetings, I think they deal with families individually to be quite honest."

We recommend that the service consults with people in developing forums, to support them in having a voice and be influential in driving improvements. For example the Social Care Institute for Excellence and the National Institute for Health and Clinical Excellence.

The registered manager said they were looking to send out surveys to support them in obtaining people's views. This information would be analysed and used to see what areas they were doing well in, and areas that require further development.

Staff told us they were given the opportunity to express their views during regular meetings and contact with the provider's representative during their regular visits. The minutes from the 11 January 2017 Heads of Department meeting identified their vision for 2017 to ensure the service was running smoothly: positive attitude, no negativity, work together, high standards and excellent reputation. The service was also looking to produce their first newsletter, which would be used as a forum to share information with people using the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People are at risk of their emotional and social needs not being met through lack of mental stimulation. Regulation 9 (1) (3) (b) (c) (d)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People are at risk because they are not provided with safe care and treatment. Regulation 12 (2) (b) (c) (f)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes are not robust, established and operated effectively to ensure risks to people are mitigated and to provide a good quality service to people. Regulation 17 (2) (a) (c) (b) (e) (f)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People are at risk because there are not consistently sufficient numbers of suitably trained, competent, skilled and experienced

persons deployed in the service to meet people's needs.

Regulation 18 (1)