GCH (Heath Lodge) Limited

Autumn Vale Care Centre

Inspection report

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Date of inspection visit:
16 May 2016
25 May 2016
01 June 2016

Date of publication:
08 September 2016

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

This inspection took place on 18 and 25 May and 01June 2016 and was unannounced. Autumn Vale Care Centre is a modern purpose built home that shares the same site as another service operated by the provider called Heath Lodge. Autumn Vale provides accommodation and nursing care for up to 69 older people, some of whom live with dementia. At the time of this inspection 61 people were living at the home.

When we last inspected the service on 13 January 2015 the provider was not meeting the required standards in some of the areas we looked at. At that time we found breaches of the Regulations in relation to the care and welfare of people who lived at the home, the management of medicines, consent and the Mental Capacity Act (MCA) 2005 and staffing levels. At this inspection we found that, while improvements had been made in some areas, there were continued breaches of the Regulations, for example in relation to staffing levels, training and governance.

At the time of this inspection there was a relief manager in post who was covering both Autumn Vale and Heath Lodge. This was because the previous manager, who had not registered with the Care Quality Commission (CQC), had resigned ten days earlier. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

The last manager who had registered with CQC left the service in March 2013. Since then nine different managers have held the post, both in permanent and temporary positions, but none completed registration with the Commission. On the first day of our inspection a new manager started their induction only to resign and leave the service five days later. The provider has appointed a new interim manager until a permanent replacement is recruited.

There were not always sufficient numbers of suitable staff available to meet people's needs consistently across all areas of the home, particularly in the dementia care unit. Safe and effective recruitment practices were followed to make sure that staff were of good character and had the experience and qualifications necessary for the roles they performed.

Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had to the relevant local authority, which included by way of 'whistleblowing' if necessary. Steps were not always taken to mitigate and reduce identified risks relating to falls and behaviour that challenged residents and staff. People were supported to take their medicines safely and in an appropriate way.

People who lived at the home and their relatives were positive about the skills and abilities of permanent care staff. A significant number of staff were not up to date with training in key areas such as safeguarding, medicines and infection control.

Staff told us, and records confirmed, that they had not had regular supervision meetings with senior colleagues to review their performance and professional development. Although staff had the opportunity to attend team meetings to discuss how the home operated, most told us they felt unsupported and undervalued.

People expressed mixed views about the quality of meals provided at the home. Everyone said they had enough to eat but some people said food was often cold when served because staff were so busy. Accurate information about people's food and fluid intakes had not always been properly recorded in plans of care or assessed properly to reduce the risks of malnutrition or dehydration in an effective way.

At our last inspection we found that consent had not always been obtained in accordance with requirements of the MCA 2005. At this inspection we found that although some improvements had been made there were still inconsistencies. For example, deprivation of liberty safeguard authorities (DoLS) had been submitted to restrict the freedoms of people who had capacity to make their own decisions.

People told us that there health needs were met in a safe and effective way and that they were supported to access health and social care professionals where necessary and appropriate.

Most relatives and carers told us they had been involved, to varying degrees, in the planning and reviews of the care and support their family members received. However, some people could not recall having been involved and their consent was not always accurately reflected in their individual plans of care.

Most people told us they were often bored as there was not enough going on at the home to keep them occupied. There were insufficient opportunities for people to take part in meaningful activities or pursue hobbies and interests that met their needs.

People who lived at the home told us, and our observations confirmed, that they were cared for in a kind and compassionate way by permanent staff who knew them well and were familiar with their individual needs, preferences and personal circumstances. However, some agency staff members did not know the service well, were unfamiliar with people's needs and, in some cases, did not have the skills or abilities to communicate effectively.

We saw that most permanent staff members had developed positive and caring relationships with people who lived at the home. They provided care and support in a respectful way that promoted people's dignity and took full account of their needs and wishes.

Friends, relatives and carers of people who lived at the home told us there were no restrictions as to when they visited and that they were always made to feel very welcome. The confidentiality of information held about people's medical and personal histories was securely maintained at the home.

People received the care required to meet their identified needs in a responsive and person centred way. However, this was not always accurately reflected in their individual plans of care. There was a system and procedure in place to record and investigate complaints but this had not always been managed effectively.

Staff at the home were frustrated by the frequent changes in management and most told us they felt unsupported as a direct result. We found that important records relating to people's care, treatment and support had not been accurately completed, maintained or updated in all cases.

Systems used to identify, mitigate and reduce risks to people and the services provided were not as effective

as they should have been.

At this inspection we found the service to be in breach of Regulations 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always sufficient numbers of staff available to meet people's needs safely.

Identified risks to people's health and well-being were not always managed safely and effectively.

People were supported to take their medicines safely.

Staff recognised and knew how to respond to the risks of abuse.

Safe recruitment practices were followed to ensure staff were of good character and suitable qualified and experienced for the roles performed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not been adequately trained or supported to meet people's needs effectively.

Although staff obtained people's consent before care was provided, the principals and requirements of the MCA 2005 were not applied consistently.

People were supported to eat a healthy balanced diet that met their needs but risks associated with malnutrition and dehydration were not managed effectively in all cases.

People's health needs were met and they were supported to access health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for and supported in a kind and compassionate way by staff who knew them well or were familiar with their needs.

Some people who lived at the home could not recall having been involved in the planning or reviews of the care they received.

People were supported in a way that promoted their dignity and respected their privacy.

The confidentiality of personal information was maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There were insufficient opportunities provided for people to pursue social interests and take part in meaningful activities relevant to their needs.

People received personalised support that met their needs and took account of their preferences and personal circumstances.

People and their relatives knew how to raise concerns and were confident that complaints would be dealt with.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had not been a registered or consistent manager at the home for over two years.

Staff lacked direction and felt unsupported and undervalued by the provider and management team.

Systems in place to quality assure the services provided, manage risks and drive improvement were not always as effective as they should have been.

Autumn Vale Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider had made necessary improvements since our last visit and met the legal requirements and regulations associated with the Health and Social Care Act 2012. The purpose of the inspection was also to look at the overall quality of the service and to provide a rating under the Care Act 2014.

The inspection was carried out on 16 and 25 May and 01June 2016 and was unannounced. The inspection team consisted of two Inspectors, an expert by experience and a specialist professional nursing advisor. An expert by experience is someone with personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 24 people who lived at the home, four relatives and 16 staff members including the chef. We also spoke with the relief home manager, area manager and other senior representatives of the provider. We received feedback from health care professionals, stakeholders and reviewed the commissioner's report of their most recent inspections.

We viewed care plans relating to 13 people who lived at the home and two staff files. We also carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 13 January 2015, we found that the service was not always safe because the provider had failed to ensure there were sufficient numbers of suitable staff available to meet people's needs at all times. At that time problems arose because of the inconsistency of staffing levels and deployment across different areas of the home, particularly in the dementia and high dependency nursing units where people's needs were greater. At this inspection we again found that there were insufficient numbers of suitable staff available, primarily due to a shortage of permanent nursing and care staff.

People and their relatives told us that nurses and permanent care staff were very busy and often stretched because of shortages and the use of agency staff who were not always familiar with the home or people's needs. One person said, "We get lots of new people [agency staff] and we don't know who they are and they just arrive, I don't like strangers [caring for me]." Another person told us, "There's not always enough staff around when you need something, so you often have to wait. Staff are kind but very stretched." Somebody else commented, "The staff are very nice and they do what they can, but there are not enough of them."

The relief manager told us that staffing had been a serious problem at the home with significant difficulties around recruitment and retention, particularly in relation to nursing staff. This meant that despite an on-going recruitment campaign, the service had found it necessary to use temporary agency staff on a daily basis. Some of these had been deployed at the home regularly over a long period of time and were therefore familiar with the service and the people who used it. However, agency staff who had not worked at the home before and were unfamiliar with the service and people's needs were also frequently used.

A staff member commented, "It can be very busy and we are sometimes very stretched. Sometimes agency staff don't turn up and then it is difficult and sometimes agency do turn up but aren't very good." Another member of staff said, "We haven't got enough staff; it's a problem here. We have more agency on today than permanent [staff]." A colleague of theirs told us, "Its hard with agency [staff] but some of them are virtually permanent as they are here so often." One temporary staff member who had not been at the home before told us they were not familiar with the service or people's needs. They had not seen anyone's individual plans of care and explained that their induction had consisted of being shown around by a permanent colleague.

Although the residential care unit was fully staffed during our inspection we found that permanent staff spent much of their time providing guidance, direction and support to temporary agency staff, some of whom appeared unfamiliar with their surroundings, responsibilities or people's needs. One permanent staff member told us, "Every day we have agency [staff], we are always short and need to work extra hours. I do my best, when I can."

Although at times staff were able to answer call bells and requests for assistance promptly, there were frequent occasions when they were too busy which caused significant delays. One person said, "They [staff] are always rushing around, I don't bother to ring the bell." Another person commented, "Whenever I need the staff I have my buzzer. Sometimes I have to wait; I understand this because there are other people to

care for." Somebody else told us, "When I call the bell sometimes its good, sometimes not great but I know they will always come. The staff all do their utmost." Although in most cases we saw that staff responded to people's basic personal care needs promptly, they were often too busy to stop and deal with less urgent requests for help, information or assistance.

In the dementia care unit we saw there were often insufficient resources to meet peoples complex needs and behaviours. Staff struggled to cope with the demands placed upon them by people with higher dependency needs, some of whom frequently displayed significant levels of behaviour that challenged others. For example, two people with a history of behaviour that challenged others were left unsupported for long periods of time while staff attended to other tasks, despite guidance in their plans of care to the effect that they required constant observation. We saw that one of them displayed such behaviour during our inspection which caused other residents in close vicinity to become anxious. A staff member commented, "You must keep an eye on [them] all the time otherwise they create havoc."

Staffing levels across the home also lacked consistency during mealtime which again meant that in the residential unit staff were busy but able to cope, whereas in the dementia care unit they often struggled to meet people's needs in a timely or person centred way. A relative of one person said, "There are often not enough staff at particular times, like meal times. If someone wanders off there's no-one to bring them back." A staff member told us that numerous people required help during meals times and that it was not always possible to help them all at the same time; "Meal time takes more than one and half hours. We keep their food warm in the hot plates. We don't have enough staff during meal times."

This meant there were not always sufficient numbers of suitable staff available to meet people's individual needs which amounted to a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our inspection the provider and relief manager took steps to ensure that staff resources were deployed more effectively in areas of the home where people's needs were greater and more complex. This meant for example, that staff were more able to closely monitor and support people who frequently demonstrated behaviour that challenged others in a way that met their needs in a safe and effective way.

At our last inspection we found that the provider had not taken the steps necessary to mitigate identified risks to people's health in relation skin care and pressure ulcers. Although at this inspection we found improvements in that particular area of care, the provider had not reduced other identified risks relating to falls and behaviour that challenged others.

Plans of care relating to one person stated that a person could be, "Aggressive both verbally and physically towards staff especially during physical care." However, there was no guidance about triggers for the behaviour or how it could be managed safely and staff told us they had not been sufficiently trained or supported to respond effectively. A relative of another resident told us how this person had threatened them with a Zimmer frame when they prevented them from entering their family member's room. Monthly reviews reported that the person was; "Still verbally and physically aggressive….staff to continuously monitor and observe as well as record behaviour."

During our inspection we saw that the person in question was left unsupported for long periods of time while staff attended to other tasks. One staff member said, "Sometimes in the afternoon it is very challenging, people start to wander and then you have to have eyes in all directions." Plans of care relating to another person with a history of behaviour that challenged again failed to provide any guidance to staff about how to keep them and others safe. A relative told us they had broken their family member's radio when left unsupported by staff.

A number of people had been identified as being at high risk of falling over and hurting themselves. Individual plans of care for one such person, who had suffered a number of falls, recommended that they have a pressure mat at the entrance to their bedroom to alert staff if they started to walk around but this had not been put in place. Plans stated they should be monitored by staff regularly but there was often insufficient staff available during our inspection to achieve this. We observed the person walk about unsteadily, unsupported and without the benefit of their walking frame on a number of occasions.

We saw in plans of care for another person at risk of falls that bed rails should not be used as they often attempted to climb over them. Plans also recommended the use of a bedside floor mat, pressure sensor and "continuous observation" when the person was up and about. We saw during our inspection that these measures had not been implemented which meant the person was at risk of falling and hurting themselves. A staff member commented, "They really need 'one to one' [care]. If left alone there is every tendency that they will have a fall." We asked a nurse about the absence of recommended measures and they said, "There must have been a change of care plan, I don't know."

Information about people identified as being at risk of malnutrition or dehydration had not been consistently maintained or responded to effectively in all cases. Accurate information about people's food and fluid intakes had not always been properly recorded in plans of care or assessed. For example, an entry for one person at risk of malnutrition stated, "Breakfast – ate porridge", but with no indication of how much had been consumed. Plans relating to other people at risk of dehydration were incomplete and unclear as to the quantity of fluids they had consumed. Another person consistently lost weight over a long period of time but had not been referred to a GP or healthcare specialist. A senior care staff member agreed that the weight loss should have triggered a review; "Yes, I don't understand why that has not been picked up."

This amounted to a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our inspection the relief manager took steps to address the failings identified and reduce the risks of harm. For example, assessments and plans of care for people identified as being at risk were reviewed by experienced nursing staff to ensure they were fit for purpose and a new audit tool introduced to help monitor progress and trigger further action.

At our last inspection we found that the provider had not provided adequate guidance to staff about how to support people with their medicines in a safe way. At this inspection we found that some improvements had been made in that regard and that people were broadly positive about how they were supported with their medicines. One person said, "They [staff] bring my medicines round on time every day, they are very good at that." However, some problems with the overall management of people's medicines were still apparent and these will be addressed in the 'well led' section of the report.

Safe and effective recruitment practices were followed to help ensure that staff were of good character and had the experience and qualifications necessary for the roles they performed. One agency staff member said the home checked they had training before they started; "It's a good place, I am happy here. I have been here a few times now." However, we found that in some cases appropriate steps had not been taken to ensure that all temporary staff had the language skills and abilities necessary to communicate with people effectively. This meant that some people who lived at the home found it difficult to understand and communicate their needs. The provider is aware of this issue and the need to make improvements in this area.

Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had to the relevant local authority, which included by way of 'whistleblowing' if necessary. However, not all staff were up to date with their safeguarding training which is an issue that will be dealt with in both the

'effective' and 'well led' sections of the report.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home and their relatives were positive about the skills and abilities of permanent care staff. One person told us, "The staff are great nothing is ever too much for them." Another person commented, "The staff are very nice and work very hard." A relative of another person said, "Permanent staff are great, know what they are doing and how to care for people. The agency staff are a different kettle of fish altogether; some are OK but some clearly don't have a clue."

Staff members told us, and records confirmed, that they were behind and out of date with refresher updates in terms of both the provider's mandatory and development training. The relief manager informed us, "We are behind with mandatory refresher training in areas like safeguarding, medicines, moving and handling and care planning." A staff member commented, "Training is a problem too and we are all behind."

Some staff had not received annual refresher training updates in a number of the provider's mandatory areas since 2014. This included moving and handling, safeguarding, fire safety awareness, medicines and infection control. In addition, a significant number of staff had either not received wider development training or where out of date. This included care planning and record keeping, dementia awareness, pressure care, behaviour management and end of life care. A staff member told us, "We haven't had training for over a year, I've only just been refreshed on my safeguarding and moving and handling."

Some people frequently displayed behaviour that challenged staff and other people who lived at the home. However, staff told us they had not been adequately trained to respond effectively. One staff member commented, "I am not trained to look after this kind of behaviour. I have asked for training but have not heard anything." Staff told us, and records confirmed, that they had not had regular supervision meetings with senior colleagues to review their performance and professional development. The relief manager said that supervisions were; "Not fully up to date."

Although staff had the opportunity to attend team meetings to discuss how the home operated, most told us they felt unsupported and undervalued. One staff member said, "I don't feel supported or appreciated." Another member of staff commented, "We are lacking support but are doing our best and maximum." A senior colleague of theirs told us, "We are a good team and we support each other but we need to be supported too."

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

People expressed mixed views about the quality of meals provided at the home. Everyone said they had enough to eat but some people said food was often cold when served because staff were so busy. One person told us, "Food is up and down, nothing I don't like; it's OK….I have enough to eat." Another person told us, "It's usually OK but stuff like omelettes is often cold and rubbery." A relative of another person commented, "I have meals here regularly and I like them, they are fine. Typical food for lots of people but OK."

We saw that staff frequently encouraged people to drink cold or hot drinks of their choice, both in communal areas and in their bedrooms. People expressed mixed views about the menu choices available at the home. One person told us, "We don't see the chef and nobody ask us about [meals]….We don't get a choice except for breakfast which is always good and cooked." However, when another person said they had not enjoyed their main course at lunch a staff member said, "If you don't like what is on the menu you can just ask for something different. The cook will always make something you like, don't forget, just ask."

Permanent staff were knowledgeable about people's individual dietary needs and requirements and offered them a choice of main courses, desserts and drinks at mealtimes. For example, we saw that one person who lived with diabetes was offered a choice of alternative desserts appropriate to their condition which they were clearly very pleased about. People told us that supported them to eat and drink when they needed help. One person commented, "They [staff] always ask me when and if I need help; some days I do and some I don't. Sometimes I need my food cut up, they ask me and do it but they don't make a big thing about it. I feel comfortable eating in the dining room."

People's dining experience lacked consistency and varied across different units at the home. We saw that in the residential care unit people were given appropriate levels of support in a calm, patient and person centred way. However, in the dementia care unit staff were too busy and stretched because of the higher dependency needs of the people they supported at mealtimes. Although permanent staff clearly knew people's needs well and interacted with them in a positive way, we saw that agency staff were more task oriented. For example, we saw agency staff ignore one person who struggled to put on a clothes protector without help and another who was upset and tearful throughout their meal. Another temporary staff member who supported a person to eat their meal did not speak or interact with them at all, other than to ask if they had finished.

At our last inspection we found that consent had not always been obtained in accordance with requirements of the MCA 2005. At this inspection we found that although some improvements had been made there were still inconsistencies, for example people's consent was not always accurately reflected in their plans of care, an issue that will be addressed in the 'well led' section of the report.

The MCA 2005 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. At the time of our inspection we found some inconsistencies in how the provider applied the principles of the MCA.

For example, we saw that deprivation of liberty safeguard authorities (DoLS) had been sought for people who lacked capacity in order to keep them safe at the home through use of a security coded door access system. However, staff had also applied for similar authorities for some other people who, according to their plans of care, had full capacity and were capable of making their own decisions. We asked a senior staff member why this had been done and they said, "To keep them [people] safe, they would not be safe if they went out on their own." Although these people had not been prevented from leaving the home, staff did not understand that DoLS do not apply to people who have capacity to make their own decisions. A number of people had asked for safety gates to be fitted to their bedroom doors, not to restrict their free movement but to stop other residents from wandering in uninvited. However, their plans of care did not accurately reflect either the reasons why they were fitted or the decision making process.

Although we found that the overall standard of 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions had improved, we found in inconsistencies with how consent was obtained and recorded about

the care some people received. For example, some people had signed their own plans of care to show consent whereas in other cases, despite people having full capacity, plans were signed by relatives. We asked a senior staff member why this happened and they told us, "I don't know really, it's easier dealing with relatives."

This amounted to a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that some people's identified health needs were not always met in a safe and effective way. At this inspection we found that some improvements had been made, most people's day to day health care needs had been met effectively and they felt well looked after. One person said, "The staff are really good they look after me." A relative commented, "Care is marvellous. Staff are very good and dedicated to the job. I would recommend this place they have been good at looking after my [family member]. I can't fault the staff it's a very difficult job." However, further improvements were required because the support provided for people to maintain good health lacked consistency in some areas of the home, for example in the dementia care unit.

People told us they were supported to access health and social care professionals where necessary. One person explained they had been referred to their GP due to hearing difficulties and another told us that staff had accompanied them to hospital for an appointment. This meant that people were supported to receive on-going healthcare support.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home told us, and our observations confirmed, that they were cared for in a kind and compassionate way by permanent staff who knew them well and were familiar with their individual needs, preferences and personal circumstances. One person said, "They [staff] are kind to me here; I'm happy here." Another person commented, "The carers are very nice. They always tell us that they are here for us. There are one or two really special ones and, one in particular, if she can help me then she will." Somebody else told us, "They [staff] are very good here, I know most of them by name and they look after me."

People's relatives were also positive and complimentary about the quality of care provided by permanent staff members in all areas of the home. One person's relative said, "The nursing staff and permanent staff are so good; they really care." A relative of another person told us, "They [staff] are kind and good." However, people were less positive about the large number of agency staff used to cover staff shortages and vacancies on a daily basis, because they did not know much about them or their needs. One person commented, "Most of the staff I know and that's fine, but the staff that come in from outside [agency] are not so good and sometimes not so kind. They don't always know what they are doing." Another person said, "The carers here are very good but the agency staff are not very good."

We saw that most permanent staff members had developed positive and caring relationships with people who lived at the home. They provided care and support in a respectful way that promoted people's dignity and took full account of their needs and wishes. For example, staff respected people's privacy and knocked on their bedroom doors and waited to be invited before walking in. When people needed support to move around because of restricted mobility, staff helped and encouraged them in a calm and respectful way while maintaining eye contact at their level and explaining what was happening and how equipment worked. One person commented, "The staff are quite good; pleasant, helpful and do the things you ask."

People enjoyed positive interactions and conversations with permanent staff who frequently laughed and joked with them and offered appropriate levels of reassurance where necessary. For example, one staff member sang with a person who had become upset and unsettled, much to their obvious delight, and this helped to calm them and lift their spirits. Another staff member helped a person locate their favourite soft toy after breakfast when they had misplaced it and became upset. One person, who became upset thinking about their partner who had passed away, was comforted by a member of staff who spent time listening and talking with them about their happy memories. The staff member told us it was important to get to know people well in order to learn about and understand their needs and personal circumstances; "While I am looking after people I talk to them."

However, we saw that most agency staff members did not make time to interact, converse with or get to know the people in their care. Instead they were task oriented and relied heavily on permanent staff for the help, guidance and support they obviously needed to provide basic care and meet people's needs. One senior staff member commented, "We do care but struggle at times [with agency staff], we do our best in difficult circumstances."

We also observed that some agency staff members experienced significant difficulty in making themselves understood when speaking with people, many of whom also struggled to communicate or understand what had been said. One person told us, "Some [staff] are difficult to understand you know; mostly agency. I'm not sure they understand me either." This issue was particularly noticeable and apparent in the dementia care setting, where most people lived with conditions that made both communication and understanding difficult for them.

Friends, relatives and carers of people who lived at the home told us there were no restrictions as to when they visited and that they were always made to feel very welcome. One person who lived at the home told us, "My family are really good, lots of them visit and sometimes they take me out for a ride in the car or for lunch; I love going out." Another person said, "My relatives visit me whenever they can, they can come at any time." A relative told us how they usually visited the home twice a day and often helped their family member at meal times, "It started off that I came and helped my [family member] with lunch, I think the staff liked it and so now I come every day, twice a day most days." Another person's relative commented, "I am always welcome here I can come at any time."

Most relatives and carers told us they had been involved, to varying degrees, in the planning and reviews of the care and support their family members received. In some but not all cases, this involvement was reflected in people's individual plans of care. A senior staff member said, "The relatives and the residents have access to the care plans."

However, people who lived at the home did not recall having been involved in planning or reviews and most knew little about what their own plans contained. One person said, "There is a book which they [staff] write in but no one ever talks to me about it." Another person commented, "I don't know anything about what they [staff] need to do for me; no one ever talks to me about it. I've never seen a care plan and I haven't signed anything." Somebody else told us, "I have no idea, perhaps my [relative] deals with all that." Some of the care plans we looked at did not consistently or accurately reflect people's involvement in the planning and reviews of their own care and support. This issue has also been identified by internal audits carried out at the home and will be dealt with in the 'well led' section of the report.

The confidentiality of information held about people's medical and personal histories was securely maintained at the home in a way that preserved and maintained appropriate levels of privacy and promoted people's dignity.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that adequate steps had not been taken to ensure that people had sufficient opportunities to engage in activities, hobbies or interests that met their needs in a person centred way, particularly in the dementia care unit. At this inspection we found that the assessment of people's social care needs and the opportunities provided for involvement in meaningful activities lacked consistency across the home and therefore required further improvement. We also found there were still insufficient opportunities for people to engage in meaningful activities or to pursue interests and hobbies that met their needs.

Most people told us they were often bored as there was not enough going on at the home to keep them occupied. One person said, "There's no entertainment here in the evenings. There's nobody about, we just sit about looking at each other. There is nothing to do here during the day either, nothing goes on. The whole time here is very boring, something to do once or twice a week would be nice. It's very dead here." Another person commented, "I wouldn't mind anything that broke up day, so boring just sitting here." Somebody else told us, "There is nothing to do here all day every day."

Some people said they would like the opportunity to play games such as cards or dominoes but when we mentioned this to staff they could not find anything suitable. One staff member told us, "We need more activity resources, there's not enough activities going on." Another member of staff commented, "There are no activities going on….Nothing happens in the afternoons, evenings or weekends." Other than people who watched television in communal lounges, we did not see any group or individual activities take place at the home during our inspection. The activities coordinator, who had not long been in post, was in the process of assessing people's social care needs and developing individual engagement profiles. They told us, "The current [relief] manager Has been very supportive and said that activities have got to get better."

Most people told us that, because permanent staff members knew them well, they received personalised care and support that met their individual needs and took full account of their preferences. One person said, "They [staff] do what you ask and do things how I like them to be done." Another person commented, "I go to the wardrobe when they [staff] are helping me to dress and I choose what I am going to wear." A relative told us, "They [staff] are very good. They ask the people who live here how they want things, like food or sometimes clothes if it is hot or cold, and then they do it. They give them a choice even when they can't really manage it….especially the senior [staff] here."

We saw that permanent staff members encouraged agency colleagues to offer people choices in line with their preferences when providing care and support. For example, one temporary staff member was told to ask a person what hot drink they preferred, "See if they would like a cup of tea, or ask them what they would prefer." One person said they wanted to have a nap after lunch and so staff helped them to their room but offered to call in on them after a while; "Shall we come and see if you want to get up again later." Another person told us, "The staff come in and talk to me whenever they can. I love music and I can listen to it whenever I want."

However, we found that in most cases people's individual plans of care did not consistently or accurately reflect their life histories, personal circumstances or preferences. This meant that new and temporary staff members who were less familiar with people did not always have access to the information and guidance necessary to help them provide person centred care and support. This was an area that required improvement.

At our last inspection we found that people had not always received care and treatment that was responsive to their individual health needs. At this inspection we found that required improvements had been made. For example, we saw that a person who lived with diabetes had their blood sugar levels regularly monitored in accordance with their plans of care and another person who was at risk of pressure ulcers received care and treatment appropriate to their needs. Permanent staff were knowledgeable about people's individual needs and the specialist equipment used to support them and reduce the risks, for example pressure relieving mattresses. One person told us, "I have 24 hours care and I am in bed all day. I am comfortable and the nurses turn me regularly. The staff ask me whether I am in pain and change my position regularly."

Most people told us that if they had any concerns they would probably raise them with family members in the first instance or with senior staff. One person said, "I did make a complaint and it was dealt with." Another person commented, "I have no complaints at all, other than its very boring. There's nothing to look forward to." There was a system and procedure in place to record and investigate complaints. However, the relief manager told us they had inherited a "backlog" of issues that may not have been resolved or properly recorded by the previous post holder.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found that the service had been well led. However, at that time the provider and senior management team acknowledged that consistent and robust leadership was required if the improvements made were to be sustained over time. At the time of this inspection there was not a manager in place who had registered with the Commission (CQC).

The last registered manager left the service in March 2013. Since that time nine different individuals have held the managers post, either in a permanent or acting capacity, but none have stayed long enough to formally register with the Commission. At this inspection there was a relief manager in place who was also responsible for Heath lodge, a sister service that shared the same site. The deputy home manager, head of care and clinical lead posts had also been vacant for some time for a variety of reasons, for example maternity leave. The relief manager told us, "We need a deputy manager as not had one for two months. The head of care role is also vacant."

A newly appointed permanent manager started their induction at the home during our inspection but resigned five days later. The relief manager has since moved on and another experienced manager from within the providers organisation has taken up the post and started the registration process with CQC. Most people who lived at the home and their relatives either did not know or where unsure who the manager was. One person said, "There have been lots of staff changes, lots, and we have a new manager I think." We found that the majority of problems identified during our inspection were directly attributable to a lack of clear, robust and consistent leadership at the home.

Staff at the home were frustrated by the frequent changes in management and most told us they felt unsupported as a direct result. One staff member said, "I absolutely hate the constant changes of manager here; it's very unsettling." Another member of staff commented, "The change in managers is ridiculous. They all come with new ideas, change [things] and then get deflated and go; its very unsettling for residents and staff. There is no morale with staff and it's very disappointing." A colleague of theirs told us, "The manager situation is madness, they don't stay for longer than a few weeks; I've lost track. The current [relief] manager is trying to cover both homes but that can't work in a month of Sundays."

The relief manager (who has since left the service) told us they had introduced weekly heads of department and unit meetings to share information more effectively, facilitate team building and provide clearer leadership. A senior staff member commented, "We have got more direction from the new [relief] manager and are going in the right direction.

We found that important records relating to people's care, treatment and support had not been accurately completed, maintained or updated in all cases. Some individual plans of care and risk assessments that required monthly reviews were last updated in November 2015 and others did not accurately reflect people's on-going consent and involvement in the care they received. For example, some people had requested safety gates to stop people entering their bedrooms but the decision making process had not been adequately documented.

Systems and processes were in place to help identify, mitigate and reduce risks in a range of key areas such as care planning and record keeping, staffing levels, medicines, nutrition, staff training and accidents but again these had not always been effective. For example, we saw that care plan audits had identified some of the failings and issues identified during our inspection but sections of the forms used record the action taken, by whom and when had not been completed. For example, an entry in one such audit noted, "Requires more family involvement in regards to signing consent and care plans" but did not state what if any action had been taken in that regard.

Although the recording of DNACPR decisions had improved since our last inspection we found they still lacked the required levels of consistency and accuracy in some cases. The relief manager told us that DNACPR's had not been audited properly, described care plans as "not good" and agreed that improvements were required in terms of record keeping overall. We saw that some medicine audits had been carried out but again these lacked consistency and, where issues had been identified, there were no clear action plans in place that detailed how these would be addressed. The relief manager was unable to clarify what steps had been taken and acknowledged that improvements were required. They told us that all plans of care were in the process of being reviewed to ensure they were fit for purpose and that a new auditing process had been implemented to improve effectiveness.

Although a dependency tool was available to assess people's needs and determine the staffing levels required to meet those needs effectively, the relief manager told us it had not been used properly. They also confirmed that no analysis had been carried out in relation to information generated by the electronic call bell system; "Response times are too slow here, we need to do some analysis around performance." This meant that staffing levels and deployment had not always been adequately monitored and assessed to improve the quality and safety of services provided. The relief manager agreed that improvements were required; "[A] lack of robust sickness management has been a problem with no return to work meetings, no analysis and no links with disciplinary system."

Systems designed to help record and investigate accidents, incidents, injuries and complaints had not always been used effectively to identify emerging risks and trends, mitigate risks or to share learning outcomes. For example, the relief manager had inherited a "backlog" of complaints, some of which had not been recorded or resolved properly, and confirmed that the analysis of information about accidents had been inconsistent and did not always trigger management reviews or action, for example in relation to challenging behaviour. The relief manager commented, "There has been no analysis or triggers for a while." We also found that nutritional audits and screening had not always identified people clearly at risk of malnutrition or dehydration and that the outcomes of infection control, health and safety and dining experience audits were unclear, inconsistent and inconclusive in some cases.

The relief manager demonstrated a new audit process that had recently been introduced and was designed to record, monitor and review performance and risks in key areas in a more effective way that also enabled more robust senior management and provider oversight. One senior staff member commented, "Document everything and do nothing is the culture here, that's what we are trying to change."

It was not clear in all cases whether staff had completed induction training programmes to prepare them to do their jobs effectively. This was because the matrix used to monitor inductions was incomplete and meant that the relief manager was unable to identify which staff members had completed induction without reference to individual staff files. An administrator had been tasked with reviewing all staff files and updating the matrix during the course of our inspection.

Previous managers at the home had allowed significant training gaps to arise in key areas such as

safeguarding, medicines and moving and handling. Neither the failings in training provision or management oversight were identified or addressed quickly enough at senior management or provider level. Although we saw that some steps were taken to resolve the problem, for example through provision of additional training resources on site, these did not form part of a strategic over-arching training plan designed to reduce the gap in the most effective, joined-up way. It was also difficult to determine whether or when staff had been given supervision meetings with senior colleagues without reference to individual personal files because the matrix used to record and monitor them had not been completed in an accurate or consistent way.

The concerns in relation to quality assurance, management oversight and a consistent management team amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had not met people's social care needs in all cases.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not always done all that is reasonably practicable to mitigate identified risks to people's health.

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 1. Systems and processes used to assess, monitor and mitigate risks to the health, safety and welfsare of service users were not as effective as they should have been. 2. The registered person had not always maintained accurate, complete and contemporaneous records in respect of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 1. The registered person did not ensure there were sufficient numbers of suitable staff available at all times to meet people's needs. 2. Not everyone employed at the service had received the training, support and supervision

necessary for them to perform their roles.