Care Quality Commission

Althea Healthcare Properties Limited

The Queen Charlotte

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 21,22 and 23 September 2015. The inspection was unannounced. The home is registered to provide nursing care and support for up 51 people. The home was not at full occupancy and was accommodating 43 people.

At the time of our inspection there was not a registered manager in post, the previous manger had left employment in December 2014. The provider had appointed a manager who had applied to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected on 11 February 2014 and found to be meeting the required standards. At this inspection we found that the provider was failing to meet the fundamental standards.

The provider did not ensure there was effective and responsive leadership within the home. The provider did not have an effective system to check the quality of care people received at the home.

Summary of findings

There were insufficient staff effectively deployed to meet the needs of the people living at the home. The impact of this was that staff had little time to sit and talk with people or to meet their social and emotional needs. It also impacted on the staff's ability to meet people's needs in a dignified and respectful manner. People could not be confident of receiving care at the time they wished because there was not enough staff to meet people's needs. People were left without social stimulation for long periods of time. People did not experience personalised positive care. Some staff failed to consistently show compassion when people were distressed.

People who had an identified risk of harm to themselves or others did not have the risk managed safely. Staff had been subject to verbal and physical abuse that was not consistently addressed. This put staff and people living at the home at risk of further abuse. Where allegations of abuse were made the provider had not made effective arrangements to investigate these concerns or give the local authority factual information regarding these concerns.

The risks people faced were not consistently acknowledged in people's care records. When people were at risk of falls through health care conditions these were not acknowledged in their care records. This meant staff had insufficient guidance to meet their needs. Care records were not always accurate and the reviewing systems of these care records were unreliable.

Staff did not receive the training required for them to meet people's individual needs. Staff spoke about their concerns that they had not received appropriate training. We observed a number of care practices that demonstrated staff required more training in order to support people in a dignified and individual way.

Medicines administered at the home were safely stored and dispensed appropriately.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

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

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

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

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

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Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The risks people faced were not reduced as staff had insufficient guidance to support them. Known risks of harm were not reduced because of ineffective care plans.

People were not safe as there was inadequate investigation of concerns and allegations.

There were insufficient staff on duty to meet people's needs safely

The medicines administration practices were safe.

Is the service effective?

Inadequate

The service was not effective at meeting people's needs.

The staff group had not received adequate training to support the people they cared for, putting people at risk of poor care.

The service failed to ensure that consent to care and treatment was adequately recorded.

The service failed to ensure that all forms of restraint was authorised in line with the requirements of the Mental Capacity Act.

People received enough food and drink throughout the day but the impact of the staffing levels and organisation meant that meal times were not always as dignified as they could be.

Is the service caring?

Inadequate

The service was not consistently caring. People were not treated as individuals and the service failed to treat people with respect and dignity.

The service failed to respond professionally and compassionately to people's emotional needs,

Is the service responsive?

Inadequate

The home was not responsive. Where people had identified needs the service failed to provide for these needs.

People were not provided with appropriate activities.

Peoples needs were assessed but the assessments lacked significant detail, reviews of people's needs were not accurate.

Complaints were addressed as described in the providers policy.

Is the service well-led?

Inadequate

The service was not well led. The manager did not provide effective leadership at the home. Staff did not feel they could influence change.

There was a lack of an effective overview of the care provided at the home where improvement plans failed to consider the quality of care people received.

The Queen Charlotte

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 visits took place on 21, 22 and 23 September 2015 and was unannounced. The inspection team was made up of two inspectors on the first day of the inspection and one inspector for the remaining two days.

The provider had not completed a Provider Information Record (PIR) prior to the inspection as we had not requested one. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information from other information we held about the service. This included notifications the home had sent us about safeguarding concerns and during our inspection through discussion with the management team and staff.

During our inspection we spoke with five people living in the home, three visiting relatives, 12 members of staff and members of the management team. We observed care practices throughout the home. We also looked at records related to 12 people's care, and reviewed records relating to the running of the service such as staff records, rotas and quality monitoring audits.

We also spoke with two care professionals who had worked with the home or had visited people living at the home.

Observations, where they took place, were from general observations. We also 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.

Inadequate

Is the service safe?

Our findings

People who had an identified risk of harm to themselves or others did not have these risk managed safely. An example of this was we observed a person shouting to a member of staff for help to get up. We spoke with senior staff on duty in the area who told us the person displayed behaviour that challenged. We looked at the persons care records to establish what guidance staff had to manage this behaviour. The records evidenced that staff had recently been 'punched in the jaw, scratched, received a broken finger and been verbally abused' by the person. However the care records had not been updated to acknowledge these events beyond recording the incident. There was no ongoing assessment to mitigate the risks relating to the health, safety and welfare of people using the service and others who may be at risk of harm. This demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one person's care record it was identified that they had a condition which put them at a high risk of falls. The persons care records in relation to their mobility informed staff that they walked independently and only required support for 'long walks'. This meant that the person was at risk of harm as their condition had not been acknowledged or managed effectively. We also noted in the ground floor dining room snacks available on a sideboard. These consisted of fruit and crisp type snacks. We had read in people's care records that some people had swallowing difficulties and needed to avoid certain foods as they put them at risk of harm through coking. Staff told us that it was possible that some of these people could access these snacks unsupported. Whilst people having free access to snacks promote a degree of independence the risk associated with this facility had not been suitably assessed. The above demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not adequately protected from harm. We spoke with a person and their visiting relative. As the person could not express how they experienced care the relative told us about their concerns over their loved ones safety. We observed that the person had bruising around the eye and dressings on their leg. The relative told us that staff had told them the person had fallen but they believed they had been punched. They also told us the person had been punched before and that there was known conflict with another person living at the home. We looked at the person's care records to see what was recorded about the incident which had resulted in bruising to the eye. The accident / incident report detailed an incident of a fall. However the daily care records and observational recording of the person did not correspond with the information in the record of an incident / accident. There was no recording of any close observation of a head injury outside of the normal observational records. This meant that the two accounts of the time the bruising happened were unreliable.

We asked one member of staff, on duty at the time of the incident, if the manager had asked them about it, they replied "no". We asked the manager if a safeguarding referral had been made and explained our concerns over the disparity of the information recorded. They told us that the person had fell and there was no need. We asked them to reconsider this. On day three of the inspection the manager told us they had telephoned the safeguarding team of the local authority and discussed the fall and it was agreed this would not go forward to investigation. This meant that despite our concerns over the recording of the incident, and with no investigation into the circumstances and evidence in the persons care records a decision was taken to treat the incident as a fall. Following the inspection we made a safeguarding alert to the local authority were we explained our concerns. This demonstrates a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People working at the home were not consistently protected from bulling and harassment. When we spoke with the manager at the beginning of the inspection we asked them if any staff were of concern to them and if any staff were subject to disciplinary action. We were told "no". During the inspection staff told us they had raised concerns with the manager about the attitudes of some of their colleagues towards others colleagues. In the afternoon of the first day of inspection we asked the same question of the manager who told us that one member of staff was of concern due to performance issues that were being addressed through supervision. On the third day of the inspection we looked at staff files and established that concerns had been raised about two staffs attitude. We asked the manager how this had been addressed. We were told that the issues raised had been dealt with informally as

the staff making the allegations did not wish to make a formal complaint in writing. The manager acknowledged that no recording of the informal discussions had been made to show that the matters brought to their attention had been addressed. This meant that there was no evidence that the issue had been addressed in line with the provider's policy and although we asked about staffing concerns we were not made aware of these until we had discussions with staff.

There were insufficient staff to meet the social and emotional needs of the people living at the home. We looked at the staffing rotas and spoke with staff about how they were deployed. There were nine care staff to meet the support needs of the 48 people living at the home. There was also two clinical staff who were responsible for supporting the care staff, administration of medicines and all clinical tasks. The care staff were divided into three to support the needs of the people on each of the three floors.

Staff told us they did not have time to sit and talk with people. Relatives told us about their concerns over staffing levels. We observed that staff were very busy in the morning supporting people with their physical needs, serving breakfast and reassuring people who were showing signs of distress. We saw that staff did not have time to spend any amount of quality time with any one person. For example we saw staff reassuring one person who appeared confused; the interaction was positive and compassionate. However this interaction was cut short as the staff member had to leave the person to support someone else as they were becoming agitated with another person. There were no other staff in the area at that time to support eight highly dependent people. We spoke with the staff member later who told us it is very difficult to meet people's needs as they have to address issues as they come up, often with no other help in the area they are working. They told us the afternoons can be very difficult explaining "people on the top two floors can, and do, come down to the ground floor to meet others, have lunch if they want or just walk around". They also told us "whilst this is good for the people living here, if the numbers of people increased due to this movement, the staff numbers allocated to the ground floor to support them do not". We observed this to be the case and saw the impact of this as staff struggled to meet all of the support needs in a dignified and person centred way.

We looked at people's care records to see what sort of support they needed. We noted in five people's care records it stated that the person required close supervision or for staff to record their (person's) whereabouts every 15 minutes. The staff told us about the problems they faced in making accurate records. They told us they usually complete the records at the end of the shift. Staff did not tell us about close or 15 minute supervision of people. Given the numbers of staff on each floor, this could lead to inaccurate recording or the lack of support and supervision to those who need it. The above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicine administration and storage were safe. Medicines were stored in locked cabinets and trolleys in locked clinical room on ground floor. Only nurses administered medications. Medicines were mainly dispensed from blister packs once people's placement was established. Controlled drugs were kept safe in a locked cupboard. The medicines fridge and clinical room temperatures were checked daily check and recorded. The medicines stock was checked daily. An improvement plan had identified the need for more storage of clinical equipment and some medicines which was being implemented during the inspection. We observed medicines being administered where the nurse signed after each one was dispensed. They remained with the person until medicines were taken. The administration of covert medicines was in line with the providers policy and agreements to dispense medicines in this way had been agreed by the person's GP, nurse in charge, relative/ advocate and pharmacist. The abbey pain scale (a recognised way of assessing pain when the person cannot tell you) was in use and in the care plans, we looked at this and it had been completed. People's care plans took account of whether or not people could verbalise and recorded other indicators which could be used to check if someone was in pain.

Inadequate

Is the service effective?

Our findings

The staff lacked the training to be able to provide for the safe care and support of people who displayed behaviour that put themselves or others at risk. All of the staff we spoke with told us they felt uncomfortable addressing 'challenging behaviour' as they did not consider they had received adequate training to support people effectively. We observed some staff struggling to cope with people whose behaviour was erratic. For example we observed one person did not wish to sit in one place for more than a minute or two. They got up and moved chair consistently, which had a negative effect on others in the area. The staff did not comment on the behaviour or interact with them on any level. We asked staff about how they supported the person, one member of staff said "sometimes they will play with a toy remote control, or we just let them do as the want, it's their choice". We asked if the behaviour upset others they told us "sometimes" but did not elaborate on any interventions when asked.

We observed that some of the care practices demonstrated that staff lacked the understanding of dementia and the need for considerate interactions with people. We noticed many incidents of "outpacing" where staff, rather than walk with the person, led the person by the hand in front of them. We also noted during meal times staff supporting people to eat, put food in people's mouths without the person finishing the food already in their mouth. This could put them at risk of choking and was not dignified or respectful.

The staff were not consistently trained to meet the needs of the people they cared for. Staff told us that they have had some training but wished for more. They told us there was no specific training in dementia care in terms of face to face scenario based training or opportunities to review what worked for individuals. One staff member told us they drew on their previous work experience, however did not think this was entirely appropriate for the people living at the home. The staff we spoke with did not make any distinction between dementia care and other mental health illness although some people living at the home had complex mental health needs. This meant that these needs were not recognised because staff had not received appropriate training to support these complex needs. This is in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at peoples care records in order to establish what guidance staff had received in relation to unwanted behaviour. One person's records evidenced that if the person became agitated and upset others then staff were to remove the person to their room. There was evidence of staff taking this action recorded in the daily records. We spoke with the manager about our concerns that this represented restraint and undermined the person's rights to liberty. The manager told us that the person health care specialist had told them this was the best thing to do in these circumstances. However no Deprivation of Liberty Safeguards (DOLs) assessment had been carried out in relation to this particular plan of action. There was no evidence that staff had been debriefed following an incident of this particular 'restraint'. No evaluation had been made to ensure that the action taken by staff was appropriate and proportionate to the presenting circumstances. This means that the action taken by staff may not have been in the person's best interest and against their right to liberty.

Staff were aware of the Mental Capacity Act 2005 (MCA) and what that meant for people living at the home. Staff told us how they offer choices to people who cannot retain information such as offering two different sets of clothes to wear or by showing people differing drinks such as hot or cold. However we did not observe these choices being offered during the inspection. We further noted that at 4.25 pm staff assisted a person to the shower room. (the staff had already told us that the person becomes confused as to the time of day) At 4.32 pm we saw that the person was sat in the dining room in their night clothes. We asked staff why this was the case, they told us that the person becomes anxious during personal care and so to minimise this they help them into their night clothes, before tea time, after assisting with personal care. Although the staff and manager told us that this was in agreement with their family there was no records to evidence this. We explained our concerns to the manager in relation to the actions of staff who by putting the person in their night clothes may disorient them as to the time of day, but we did not receive a reply that would suggest that this practice would either change or be reconsidered as a best interest decision. The above demonstrates a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mental capacity assessments were generally meeting the requirements of the Mental Capacity Act (MCA) 2005. For

example, one person who had recently taken up residence had a mental capacity assessment which established they did not have capacity to make certain decisions. Likewise people's care records showed that consideration had been given to people's capacity to make decisions for themselves. However the initial assessments of need lacked a certain amount of detail such as who had been involved in the assessment process. In two of the initial assessment records it stated that only the person was involved in the process. As these two people lacked capacity to make decisions (as recorded in the assessment) it was not clear who had made the decision (and with what authority) to agree to move into the home. We spoke with the manger about this who told us that others had been involved but acknowledged the computer records did not evidence this. This meant that the care records were not accurate. This is in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not consistently treated in a dignified manner during the lunch time period. We observed the lunch time service on the ground floor of day one of the inspection. There were three staff trying to support 16 people, eight in the lounge area, eight at the dining tables. We saw that one staff member was trying to support three people to eat their meals. This meant that none of the people had the full attention of the staff member supporting them. We noted that other people had to wait for up to ten minutes to have their meal brought to them. Some people were observed as being impatient with this. Staff told us that due to the high support needs of the people living at the home it made it difficult to ensure all had their needs met at meal times. One staff member told us "I know it's not right to serve two people at once but unless I do someone will have to wait". Another staff member told us "if the front door bell rings we have to answer it which means we have to leave the person who we are supporting". We observed that three people got up and left their meal without finishing it and proceeded to just walk around. The lack of staff at this time meant that people were not encouraged to sit and eat their meal when they became distracted.

We spoke with senior staff about people's nutritional needs. They told us that some people are at risk of unplanned weight loss. They told us about the systems that they had in place to monitor people's weight to ensure people's care plans could be altered to support their needs as required. However they also told us about the problems with recording information about what people had eaten and drank throughout the day. One staff member said "In an ideal world I would record what I have supported a person with (in relation to food and drink) at the time, as it needs to be recorded on the computer I don't get the time until later in the day". This meant that up to date records were not always available and opens up the possibility to human error in recording.

We spoke to people about the food and drink at the home. One person told us, "the food here is good, all home cooked". Another person told us that food is available by way of snacks and biscuits throughout the day. One person told us about the choices they had at meal times stating "there is enough choice, if I don't like anything on offer I am sure staff will get me something different". We spoke with a relative who told us "the food here looks good; I have heard no complaints." One person told us "the portions are to large" another said they were too small". We spoke with the chef who could identify what people liked, what food some people should avoid for health reasons, and about the flexible arrangements to offer what people wanted. We looked at the menus for the last two weeks. These evidenced that some choice was offered and when required further alternatives had been made available.

People were enabled to access health services. Examples of this were that one person was due to visit the dentist on the day on our inspection. Arrangements for this were recorded appropriately in the event section of their care plan. Another person was due to attend the hospital the following day for a specialist assessment and we saw arrangements had been appropriately recorded. Where specialist health care professionals advice had been sought this was recorded in people's care records.

Inadequate

Is the service caring?

Our findings

Staff did not always demonstrate that they treated people with empathy and kindness. We talked with one person on the middle floor who had been sat next to the nurse's station most of morning. They were willing to engage in conversation and we spoke about things that seemed to interest them. Later in the afternoon we spoke again with them and asked them if they liked living at the home they replied "no I would do anything to leave." We later observed them trying to interact with a staff member walking around the area who ignored them. We spoke with the staff member who told us 'they (person) has a lot of paranoid delusions." We later observed the person became visibly frustrated saying to staff who did not have time to chat "don't go!" then "it's like talking to a brick wall."

We observed one person who frequently became distressed and sought close physical contact with others including people, visitors and staff. At one point they held our hand and began crying. We looked at their care plan which whilst making reference to their frustration did not refer to this obvious sign of distress. We saw that when staff had time they offered this person comfort and reassurance, which they clearly found calming. However on other occasions we observed staff walked past ignoring their distress as they were busy with other tasks. The persons care records detailed ways to engage them in activities which may lessen their distress. However the relevant section of the care plan did not refer to low mood or crying and had not been updated since April 2015. This either meant that this distress was a new or emerging need or that the care records did not give staff sufficient guidance to meet their needs. The above demonstrates a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that there was not an overall approach or ethos to care in the service. Whilst staff mostly spoke kindly their method of communication was overwhelmingly verbal. Some staff used touch to convey reassurance; however this was fleeting as they were frequently called away to another person whilst this was taking place. We did not observe other methods of communication taking place e.g. use of white boards, visual aids, music. When we raised the question of activities with staff and manager they spoke about the risk of over- stimulation, but this did not appear to be a risk on any day of the inspection.

People did not always have consistent care that met their needs. We observed that one person had 1:1 support throughout the day. The staff supporting the person were provided by an outside agency, one agency worker supported the person in the morning another in the afternoon. The staff member supporting in the morning was seen to 'lead' the person around the ground floor, the staff member supporting the person in the afternoon spent more time talking to them, taking things at their pace and encouraging interaction. An example of this was when the person wanted to stand but was unsure why, the staff member took their hand and danced with them to the music playing, the person appeared to enjoy this and showed pleasure by smiling and participating.

We spoke with relatives about the care their loved ones received. Some told us it was good, some said they could do much better if there were enough staff to provide activities and more social stimulation.

Inadequate

Is the service responsive?

Our findings

People were not provided with activities based on their needs or interests. We observed there was little to stimulate people or to counteract the negative impact of boredom. We saw that people were offered some activities that were not age appropriate such as photo copied children's colouring sheets and children's toys. One person was offered a number of colouring sheets by staff, they sat down and put a red line on each of the sheets and walked away. The staff member was not in a positon to offer any encouragement with this activity as they were involved with other people's physical care needs. We observed this activity on all three days of the inspection.

We spoke with staff about what activities people like, three said watching the television. We noted on the first day of the inspection on the first floor a recording of 'Dads Army' was played non-stop for three hours. All of the staff we spoke with told us they do not have time to sit and talk or provide the stimulation that people need. One person told us they like to go out shopping in the town; we observed that over the three days of the inspection they spent their time going around the building appearing to want staff interaction. We spoke with the staff and manager about this person's social need. Whilst it was clear they knew that the person liked to go out to the shops there was no evidence in the persons care records that the provider facilitated this. The manager told us that the person's relatives sometimes take them out when they visit. This demonstrates a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's care records in relation to people's choices and how they were recorded. There was a section in the care plan format 'all about me' and 'choices'. In three of the 12 care plans we looked at this section had not been completed. As a number of these computer held records did not indicate they had been reviewed since April 2015 we asked the manager how people's needs were reviewed. We were told that the reviews had been completed and showed us paper records of the reviews. We looked at the people we had identified with no records in relation to 'all about me' and 'choices'. The review informed that all sections of the care records including 'all about me' and 'choices' had been reviewed and found to be meeting the providers requirements and people's needs. This meant that the reviews were inaccurate as there was evidence that the section 'all about me' and 'choices' had not been completed as required by the provider. This is in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments did not consistently include sufficient detail about the person such as their mental health, history and likely reaction to coming to live in a care home setting. The assessments did not provide specific guidance about how staff could address specific issues arising from this. There was no record of the views of people or relatives in the care plans in relation to their care. Records about people's previous home circumstances were brief. The manager told us prior to admission they considered which floor the person would be best suited to e.g. upper floor was considered a 'quieter floor'. The ground floor being used for people who were less mobile. We did not see any evidence that consideration had been given to how people got on together, at the initial assessment stage, i.e. in terms of those people who were still quite vocal and those who used more gestures to communicate.

Three members of staff told us they did not get to know who was coming into the home until 'the morning they come in." A member of staff said "I try to read the care plan as soon as I can and allow the person to settle in". We were made aware of two people who were living on the same floor did not get on which had resulted in a degree of aggression. The staff were aware of this and told us they keep them apart as much as possible. However there was no recorded evidence that the situation had been managed or that consideration had been given to moving the room of either of the people to a different floor.

People who could articulate their views knew how to make a complaint if they wished to. One person told us that, "if I don't like something I ask staff to sort it out. A visiting relative told us they had raised issues with staff who had addressed them without fuss or concern. The provider had a complaints procedure which informed people what they needed to do to make a complaint and the time scales for the complaint to be rectified.

Inadequate

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager in post. However a manager had been appointed and had submitted their application to become registered. The manager was supported in their role by an independent quality assurance consultant and the operations manager. The manager told us about initiatives that had been undertaken such as a 'bench marking audit' to understand where the home could improve. From this audit an action plan had been drawn up. The date of the action plan was the 21 September 2015, the first day of the inspection

The action plan in place to make improvements to the service did not consistently seek to improve the quality of life for people living at the home. The action plan acknowledged the need for staff training in behaviour management, staffing levels to be reviewed, need to promote activities and supervision of staff. It also commented on many housekeeping issues and the need to update the medication / clinical room. We observed that the clinical room was being updated and systems improved during the inspection. However there was no comment or audit on the care recording and delivery of care at the home.

We noted many areas where care practice could be improved such as staffs understanding of dementia care and the supervision of people who could harm themselves and others. Whilst this was highlighted in the action plan it was of concern that these issues had not been considered in between the last inspection and this one. The action plan did not include reference to the care records to establish if what was recorded as the actions to take when supporting people were being consistently carried out by staff. Areas of care practice such as restraint did not feature in the bench marking audit. This meant that care delivery was either seen as appropriate or that it had not been considered.

There was no evidence of systematic consideration of staffing levels which ensured that skill mix, ratio and numbers of staff were adequate to support the complex needs and numbers of people with dementia being cared for. There was a lack of an effective overview of incidents or peoples specific needs relating to challenging behaviour, people who needed support with eating or how shift patterns could promote person centred routines. The above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received support and supervisions form senior and management staff at the home but this was not effective at addressing the concerns the staff identified. We looked at a sample of the supervision records that evidenced that staff had opportunities to talk with senior staff about what concerned them. Staff told us that although they had team meetings and one to one time with senior staff they did not feel they could influence change at the home. Staff told us about their concerns around team work and feeling under stress to complete records when people wanted their time. They told us about their concerns that they don't have enough information in relation to new people coming into the home and how their needs are to be met. Through discussions with staff and with the management we did not get a clear understanding of the ethos of the home and although staff spoke about person centred care they did not tell us about initiatives to improve the service to be able to provide this.

When we spoke to the manager about improvements, the main issue they conveyed to us was to re site the reception area to provide welcoming area for guests. They told us about how 'things going missing' in the existing area and that the new reception area would be inaccessible for people without staff support.