GCH (Heath Lodge) Limited

Autumn Vale Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Autumn Vale Care Centre is a modern purpose built home that shares the same site with 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 43 people were living in the home.

This inspection took place on 08 December 2016 and 20 December 2016 and was unannounced. When we last inspected the service on 18 and 25 May and 01 June 2016 the provider was not meeting the required standards in all of the areas we looked at. We found breaches of the regulations in relation to providing safe care and treatment, staffing levels across the home, supporting staff development, consent was not appropriately sought or documented, meeting people's individual social needs and ensuring governance systems were effectively operated to monitor the quality of the service provided. We served the provider with a notice telling them they needed to improve by 31 October 2016.

At this inspection we found that improvements had been made, however there were areas that continued to require improvement, particularly in relation to the service being well led.

People were supported by sufficient numbers of suitable staff, however further improvements were required with assessing staffing levels particularly in the dementia care unit where staff were less responsive to people's needs. The provider had successfully recruited and built a permanent staff group within the home and used minimal temporary staff. 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. Risks to people's safety and welfare were responded to and addressed to reduce identified risks. People were supported to take their medicines safely and in an appropriate way.

People and their relatives were positive about the skills and abilities of the permanent care staff. Training had been provided to staff in key areas, and further training was booked for the future. Staff told us they felt supported by their line manager, but felt anxious about the lack of consistent management due to the departure of numerous managers in the last years. Staff told us, they had supervision meetings to review their performance and professional development.

People's consent was sought prior to care being provided and where people lacked the capacity to make their own decisions, the requirements of the Mental Capacity Act 2005 were followed. People at risk of weight loss were supported adequately and those at risk were responded to promptly. People were supported by a range of health and social care professionals with their health needs when they required this.

People were cared for in a kind and compassionate way by staff who knew them well. Staff were observed to have developed positive and caring relationships with people who lived at the home. When personal care was provided, this was carried out in a respectful way that promoted people's dignity and took full account of their needs and wishes.

People were able to pursue their individual interests however there were not always sufficient opportunities for people to take part in meaningful activities. People and their relatives knew how to raise concerns; however the constant changes in management meant people were not always confident that complaints would be dealt with.

There had not been a long standing, consistent manager in the home for three years and the last home manager had resigned from their post shortly before this inspection. None of the managers who managed the home for various length of time registered with CQC. Staff, people and relatives felt anxious about the constant management changes at the home.

Improvements had been made to monitor and improve the quality of care people received by reviewing the systems used; however, these were not always consistent in identifying areas for improvement. People's records had been reviewed and transferred to a new care planning system; however, some improvements to recording were still required to ensure records were accurate. The provider had undertaken a comprehensive review of Autumn Vale and all the other Gold Care Homes. They recruited a number of senior managers to support the changes they wished to make in all their homes. We saw plans were developed to support and drive improvement across a number of the provider's homes, however at the time of inspection it was too early to measure their effectiveness and this will be further reviewed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of staff available to meet people's needs safely, however some people we spoke with were still unhappy with staff`s responsiveness.

Risks to people's health and well-being were managed safely and effectively.

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 suitably qualified and experienced for the roles performed.

People were supported to take their medicines safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received training appropriate to their role.

Staff felt supported by their line manager, although the numerous changes to the home manager affected their morale.

People were asked for their consent appropriately before care or treatment was provided.

People's nutritional needs were met and staff regularly monitored and reviewed people's weights and fluid intake.

People were supported by a range of health professionals when required.

Is the service caring?

Good

The service was caring.

People were cared for and supported in a kind and

compassionate way by staff who knew them well.

People who lived at the home felt listened to and involved in shaping their care.

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 not always sufficient opportunities for people to take part in meaningful group activities relevant to their needs.

People and their relatives knew how to raise concerns, however the changes in management meant people were not always confident that complaints would be dealt with expediently.

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

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had not been a consistent or Registered Manager in the home for three years.

Improvements had been made to monitor and improve the quality of care people received by reviewing the systems used, however, these were still being further developed and were not always consistent in identifying areas for improvement.

People's records had been reviewed and updated and transferred to a new care planning system, however, there remained some inaccuracies regarding people's care.

The provider had undertaken a comprehensive review of both Autumn Vale and Gold Care Homes and had implemented a range of measures to support staff, people using the services and management.

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 08 December 2016 and was unannounced. On 20 December 2016 we asked the provider to submit further evidence in relation to staffing in the home. The inspection team consisted of two Inspectors, two specialist professional nursing advisors, and an expert by experience. The specialist advisors who accompanied us were an occupational therapist and a nurse with expertise in supporting people with dementia related nursing needs. 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. We spoke with the local authority social services, clinical commissioning group professionals and the local authorities safeguarding team to ask their feedback about the services provided to people in Autumn Vale.

During the inspection we spoke with 14 people who lived at the home, five relatives and nine staff members. We also spoke with the manager, regional manager, the provider and other senior representatives of the provider.

We viewed care plans relating to 11 people who lived at the home. 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.

Good

Is the service safe?

Our findings

At our last inspection on 18 and 25 May and 01 June 2016, 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. We also found that actions were not taken to mitigate and reduce identified risks to people's well-being.

At this inspection we found that some improvements had been made. Feedback from people and our observations showed that although sufficient numbers of staff were employed to care for people safely, staff could be deployed in a more effective manner to better respond to people's needs.

People we spoke with told us they felt safe living at Autumn Vale, and said they felt there were usually sufficient staff to meet their needs. One person said, "Most of the time it is fine, but when they are busy things drag on bit, like the medication round, or lunch." A second person told us, "It has been a lot better lately with the numbers of carers about, we still wait a bit, but it's nothing like before." On the day of inspection we observed that the medication round was completed promptly and people`s call bells were answered in a timely way. We observed meal times were busy and staff supported people to eat and drink in an unhurried way, however this meant that some people had to wait longer for staff`s assistance.

Staff we spoke with told us that current staffing levels were sufficient. One senior staff member told us that one unit containing 17 bedrooms was closed and the current staffing levels were sufficient to meet peoples` needs. They told us that if the unit was reopened the current staffing will not be enough to meet peoples` needs in a timely way.

Since the last inspection the provider had successfully recruited a number of staff, and had internally promoted one staff member to the role of unit manager. We saw that use of agency staff was minimal. This had significantly improved since the last inspection; however the deployment of staff across all areas of the home was still under review. Although, staff did not rush to support another person whilst busy assisting another person, we found that people did experience a slight delay for things such as assistance at lunch time, which was inconvenient for them. However, we found that although at times people were frustrated by these delays when people required support to remain safe they had received this.

Since the last inspection the provider and management team had supported staff to rewrite people's risk assessments and care plans, this was a piece of work that was continuing as risk assessments were further developed. However, a new chart called the 'global care plan' had been introduced which provided a snap shot of each person's needs such as mobility, dementia, pressure care, or those at risk of weight loss. This was also a document sent with people if they were admitted to hospital or for information for any visiting health or social care professional. These gave a clear direction to staff of the risk and how this should be managed, also helping to ensure that risks would be managed consistently if people needed to move across services or if professionals needed to review a person's needs. For example, one person`s global care plan gave a quick overview of the person`s current needs and treatment. It described that the person had been on monthly weights, but as they were losing weight, staff had increased their monitoring to weekly weights,

referred them to dietician and GP and was given a nutritional supplement twice daily. In addition because they developed a pressure ulcer the skin care and tissue viability assessment had been reviewed, appropriate air flow mattress was put in place, alongside regular repositioning and creaming regimes and at the time of the inspection we found that their pressure ulcer has healed.

Staff were knowledgeable about risks associated with people`s daily living. Staff told us risks were identified and plans were in place for each person to offer them guidance in how to mitigate the risks and keep people safe. One staff member said, "Every staff member is encouraged to read the care plans and get to know the residents. We are informed at handover if there are any risks or people`s condition changed. It is very good because we know people and all the risks." Each staff member we spoke with was also able to provide us with an accurate update of peoples current needs and able to describe how these were met.

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. They told us they had regular training and the processes in the home regarding safeguarding people had improved. Staff completed weekly body maps to identify they picked up on any unexplained bruises or marks on people`s skin which could have triggered a safeguarding process. One staff member told us, "We are doing weekly body maps and we report any concerns to the senior staff. Residents are much safer than before."

Staff knew how to report their concerns internally and externally to local safeguarding authorities and they were knowledgeable about whistleblowing procedures. One staff member told us, "I am not afraid to report any concerns and if I am not happy how the senior staff is acting I can always report to CQC or the local authority." The provider had introduced a new form that they completed every time they reported to the local safeguarding authorities and this enabled them to effectively track any new safeguarding alerts, and on a regular basis, the manager reported to the provider any incidents or injuries that had occurred in the home.

Staff told us before they started working at the service they went through a thorough recruitment process where their employment history was explored, references were asked from their previous employers and a criminal records check was done to ensure they were suitable for the roles they had to perform.

We observed on the day that the medicines rounds were completed promptly and on time. We checked medicine administration records (MAR) for those medicines that needed to be given at specific times, for example, early in the morning, or just before, or after food, or specific days of the week and saw these had been given as prescribed. MAR charts were accurate and completed appropriately when medicines were given, and records of medicines received or disposed of were accurately maintained. MAR charts contained a colour picture of each medicine to assist staff with identification, and regular reviews of those people on sedatory medicines or those used to control behaviour were undertaken. We saw evidence where a significant number of people had ceased taking such medicines under the guidance of a doctor.

Where people were unable to communicate their needs to staff, for example where people may have discomfort through continence or pain, staff had developed a concise protocol that identified where a person may be in discomfort and were able to administer pain relief when it was required. Where people required their medicines to be administered covertly, staff had sought the involvement of the GP and pharmacist and where appropriate had consulted with people's families.

Senior staff conducted regular spot checks of medicines held, and members of management carried out a weekly audit of the processes and stocks to ensure people had received their medicines safely. The home had recently been reviewed by both an independent pharmacy and the local authority and no significant

issues were found.

Good

Is the service effective?

Our findings

At our previous inspection we found that mandatory training had not been provided to staff when required, and key additional areas of training was not provided as needed. At this inspection we found significant improvements had been made in these areas.

People told us they felt staff had the necessary training to provide care to them effectively. Records we looked at showed that staff had received key training in areas such as safeguarding and moving and handling, and some specialist training in end of life care, dementia and advance care planning had also been provided. Where training had elapsed, for example infection control and mental capacity these were booked to be delivered in the near future. One person said, "With the new staff, less of the temporary lot, the consistency has brought about a much more professional feel to the place."

Newly employed staff were required to complete a structured induction programme, during which they received training relevant to their roles, and had their competencies observed and assessed in the work place. One staff member told us, "Although I worked in care before, when I started here I had an induction and I was observed how I do manual handling." They told us that after their training they worked with experienced staff until they were competent to work independently.

Care staff told us they were supported and listened by their line managers. One staff member told us, "My manager is very good. They are always ready to offer advice and guidance if needed." Another said, "My manager and the nurses are very helpful and supportive. I do feel supported by them." However staff in more senior positions such as nurses or senior care staff felt that the support they were getting was not consistent because of numerous general management changes in the home. One nursing staff told us, "We nurses know what we need to do, but we need consistency in the top management because we need to learn more and have somebody to offer us advice."

Following the previous inspection the provider had recruited a dementia lead to support all their homes in the area including Autumn Vale. They were present in the home during our inspection and were seen to be evaluating the care provided, and identifying areas where staff needed further development. The provider told us the role of the dementia lead was to support managers to develop a dementia action plan for each home and use observations of dementia care delivery to review and develop enhanced care. They would further provide individual and group staff training as required and support staff dementia champions within Autumn Vale. During the inspection the dementia lead was conducting their observations around the home and supporting staff on the units with good practise. In addition, champions had been trained in various areas to support staff and cascade good practise in various areas such as falls and dignity. The falls champion is being further supported to attend training to add physiotherapy facilitator to their training with additional training booked for January to develop staff to assess people's moving and handling needs. With other areas of training booked to support the role of the champion within the home, the provider aims to develop a team of internal trainers who will also provide training for other staff. Other areas where staff had been supported to develop further included working closely with the district nursing teams and local hospices to improve care for those people who were end of life or who lived with dementia.

At our previous inspection we found that people's consent had not always been sought and documented and the provider did not act in line with the principles of the Mental Capacity Act 2005 when making decision for people who may lack capacity. At this inspection we found significant improvements had been made.

Staff were observed to gain people`s consent when assisting them. We heard staff asking people, "Can I put this apron around you to keep your clothes clean," and, "Shall I put a cushion there to hold your head up." Staff waited for people to acknowledge and respond before they proceeded. However we also saw that staff acknowledged where people did not provide their consent. For example, one person who was in their room, sat in the armchair was asked if they were ready for assistance with showering. They told the staff member they were not ready and to come back later, which the staff member acknowledged and returned later in the day to offer this again.

The Mental Capacity Act 2005 (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 the provider had applied the principles of the MCA to all those we reviewed. We saw that capacity assessment had been completed for specific decisions such as the use of bed rails and these had been regularly reviewed. People's families where appropriate had been involved in the decision making. Staff spoken with were knowledgeable about the principles of the MCA. One staff member told us, "We always consult with the family, GP, social worker and managers if we need to take decisions in people`s best interest." Staff demonstrated they followed the least restrictive process to keep people safe. For example using bedrails to prevent people rolling out of bed and for others they used a low raise bed and a crash mat.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff told us about people who lacked capacity to take certain decisions and had restrictions applied in order to keep them safe. We found that where people who had DoLS authorisation in place the least restrictive methods were considered and used to deprive them of their liberty. In addition the manager reported to the provider when a new DoLS application had been made through their internal reporting so these could be further monitored and reviewed. We observed during the inspection that a review was being carried out by a relevant professional to ensure the conditions of one person`s restriction were being met.

People told us the food provided at Autumn Vale was pleasant and there were sufficient quantities. One person told us, "It's not the Ritz, I'll grant you but it`s decent food with a lot to choose from." People were provided with sufficient drinks and snacks throughout the day, and where finished their meal staff were seen to offer them further helpings. People who did not eat their meal were offered an alternative if they wished, and staff were aware of people's dietary needs, such as those on soft or pureed meals and supported them appropriately.

We observed some people had to wait for longer on the day of inspection to receive their meal. Some people who lived with dementia became restless whilst waiting. Where some people, particularly in the residential lounge, waited for periods without their meal, staff had prepared them for their lunch by placing protectors over their clothes or bringing cutlery. This then left people expecting their meal to be imminent when they then waited for half an hour before they received their meals. This was an area identified by the manager and the dementia lead as needing to improve.

However staff monitored and recorded people's nutritional and fluid intake who were at risk of malnutrition. People were weighed regularly and where weight loss was identified staff quickly informed the person`s GP and a dietician to ensure they had specialist advise in meeting people`s nutritional needs. Staff also monitored people`s fluid intake. Night staff recorded and totalled people`s fluid intake over a 24 hour period and at hand over in the morning staff were informed of people who had a lower intake than usually to encourage them to drink more.

People told us they were able to see a GP, Optician, chiropodist when they chose, and care records we looked at demonstrated people were supported by a range of health professionals. One visiting health professional told us, "They [staff] will refer to us when needed and listen to the advice and plan of care we put in place. If there are any concerns then they phone straight away, so I think things have greatly improved in recent months."

Good

Is the service caring?

Our findings

At our previous inspection we found that agency staff members did not make time to interact, converse with or get to know the people in their care. The care they delivered was task oriented and relied heavily on permanent staff for the help. However at this inspection we found improvements had been made.

People we spoke with told us staff were 'nice' and that there was, 'a genuinely caring attitude shown to them.' One person told us, "Things are a lot better now that the staff are the same; I feel I have built a rapport with them [Staff] and feel they listen to me."

We observed throughout the inspection that staff were friendly, courteous and smiled when approaching people. We saw sensitive and kind interactions between staff and people who used the service and that staff were able to adapt their communication and approach to people`s individual needs. Staff addressed people using their preferred names and it was clear that staff knew people well. We saw that the way people related to staff demonstrated good relationships had formed between them. We observed one person who was upset and unsettled, feeling alone and frightened. Staff were seen to immediately approach this person, leading them away to a quiet area, talking about their family, and then spending time with them until they felt more reassured. This person was seen throughout the afternoon to be visibly more content and their spirits lifted.

Since the last inspection the provider had introduced a dignity network where care staff attended the launch on 9th December. Staff were given a copy of, 'The Dignity Audit tool' to complete in their workplaces along with a variety of dignity related competencies. These would help to identify areas that could be improved upon, and also staff were able to promote best practise among themselves through peer to peer observations. Future meetings were arranged with the next meeting looking at ways staff could promote a dignity day where awareness and education around issues affecting dignity and diversity could be promoted.

Throughout the inspection we saw people's relatives visiting, who were greeted warmly by staff when they entered the home. People told us that their relatives and friends were able to visit when they wished and stay for as long as they wanted without restrictions. We saw during the inspection that relatives came to take people for lunch, out for a day trip, spend time with people in their rooms or join them for lunch. One person told us, "[Relative] works so it's difficult to come sometimes, but they might come at night or early and it's never a problem, if I'm in bed the staff change things to get me up and about for the day to greet them."

When entering people's room's staff knocked on bedroom doors and greeted people when they went in. When staff entered people's rooms they closed bedroom doors when they offered personal care and then made sure people looked presentable and well kept. When we arrived at Autumn Vale in the morning, those people who were up and out of bed were clean, well-groomed and dressed in clean clothing. People had their items of jewellery, hair brushed and items such as their handbag placed near to them. One person told us, "They get the little things right, [Staff member] knows that this broach goes with this cardigan, things like that."

People, relatives and staff told us they had reviewed and updated people's care plans since the last inspection. We saw that for all those people we reviewed a new format 'Global Care Plan' had been put in place that incorporated the views of people about how they received their care. Where people were unable to express their views, then the opinions of their relative had been sought, and staff had used their knowledge of the person to develop a person centred approach. People spoken with gave varying degrees of awareness about their care plans. Some people told us they were not interested in reviewing them, and left this to their relatives to do, whilst others were keen to show us and knew what their plans contained. The manager told us that they were continuing to review the care planning approach and were developing this to further reflect the views, opinions and wishes of the people living at Autumn Vale.

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 previous inspection we found that there were insufficient opportunities provided for people to pursue social interests and take part in meaningful activities relevant to their needs. We found at this inspection improvements had been made in some areas, however, further improvement were still required.

People we spoke with told us that they were now better supported to engage with social activities or personal interests, however also felt that more could be done. One person told us, "Days are different, some days there is a lot to do, some days there is very little to do, or there is things going on I don't want to do. It would be nice to have more of the activity girls as the one we do have does a great job, but it's hard to please everyone."

There were a range of activities provided by one activity staff member and outside entertainers had visited the home on occasions. People told us there had also been a summer party and fete which was held in conjunction with the providers other home that shared the same site, alongside joint coffee morning's, shared church services and wheelchair dancing." On the day of the inspection we saw staff spending time with people who were in their bedrooms throughout the day. People who were sat in communal areas had a staff member permanently looking after their needs and engaging in conversations throughout the day. In the communal lounge seasonal music was playing and some people were singing along, however the same record was heard playing repeatedly all day. The manager told us that they had identified there had been a focus on improving the care in the home, ensuring people's needs had been reviewed and were being met as needed. The manager told us that in their opinion the role of the activity co-ordinator was to co-ordinate what was happening in the home, and that care staff could assist with providing activity or one to one time as needed. We found that although on the day of inspection people were supported to engage with stimulation and activity, and staff made an effort to occupy people's time on a one to one basis, this was not consistently provided and not always possible.

Those people not engaged on the day of the inspection in making Christmas cards were in the lounges or their bedrooms. Televisions in communal lounges were on, but not with appropriate programs playing, and none of the people observed across the home were watching. However, in other areas staff were positively engaging with people, for example staff initiated playing music for one person in their mother language which they thoroughly enjoyed, and a second staff member was seen to dance and sing with another person to Christmas songs they enjoyed in the morning.

The environment within the home did not support people living with dementia to reminisce or be stimulated by the decorations in the home. Walls in Poppy unit were plain, with pictures irrelevant to the people who lived there. There were few rummage items available for people to use, and the units each had a sterile and clinical feel to them. However, the provider showed us plans of how they planned to completely redesign the units to incorporate murals, colour, rummage equipment, appropriate pictures among other things. They called this the , "Autumn Vale enlightenment scheme," and this was designed to both change the environment to suit people living with dementia, and also challenge people's perceptions about dementia care." They introduced us to the designer they had commissioned to implement these changes

and who would also be responsible for bringing these to other local homes operated by the provider. It was clear to us that the provider was fully aware of the need to both individualise activity, and also to enhance the living environment of Autumn Vale, and with the appointment of specialist dementia lead, we found that plans were in place for this to be overhauled and implemented in the near future.

We found that the information in the care plans enabled staff to understand what people`s needs were and how to manage any risks involved. We found that care plans were inconsistent in providing information to staff about people`s likes, dislikes and their preferences regarding the care they needed. For example, one person with behaviour that challenged others was lying on the floor in the communal lounge. We discussed this with a staff member and they told us that this person liked to slip from their chair onto the floor and spend time there. We saw that staff then were unsure of how to proceed with this person`s needs. Eventually they placed the person on a mattress on the floor with the use of a sling. However neither staff member was entirely comfortable with this intervention. Once completed, the person was seen to be comfortable on the floor and was actually resting. Later staff used a hoist to put the person back in the chair and again they seemed comfortable.

Staff had responded to this person's behavioural need; however they had no guidance in the care plan to follow and ensure that the method they used was the correct one. When we looked at this person's care plans, staff had recorded their preference was to slip to the floor but the detail of dealing with his challenging behaviour was brief and lacked further detail, particularly about potential interventions for staff to try.

People we spoke with told us they were able to raise a complaint with the staff who supported them, however, most people told us they were not confident they would be dealt with sufficiently due to the changes in management. Where complaints had been raised since the last inspection these had been reviewed, investigated and responded to, in addition to being reported to and monitored by the provider. However, the overall opinion of people and relatives was that the changing management had led to apathy around complaints being resolved. One person told us, "To make a complaint I need to know who to complain to, and I'm told the lady who was here is not anymore, so where do I go, sometimes it's easier to get on with things and not bother them."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found 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. Also systems in place to quality assure the services provided, manage risks and drive improvement were not always as effective as they should have been. We found at this inspection that some improvements had been made, however the service continued to not meet the required standards and required further development.

Since the last inspection, the provider took the decision to voluntarily close one of the units, due to a lack of staffing and concerns raised by both CQC and the local authority. This consequentially reduced the overall capacity of Autumn Vale from 69 people to 43 people. This enabled the provider to assess the improvements required, and reduce the pressure on the staff and people living in Autumn Vale.

During the last inspection, the previous manager had resigned and an interim manager had been appointed. Prior to this inspection this interim manager had also resigned and had been replaced by a new manager, who although was in the process of applying to CQC to register. Autumn Vale Care Centre had not had a registered manager for three and a half years. The last manager to be registered at Autumn Vale resigned their post in March 2013. The provider was told at the last inspection this was an area that required improvement, and continued to do so. This was a breach of the Provider's registration. This was because the registration of the service was subject to a registered manager condition being imposed that the provider failed to meet.

People we spoke with gave varying views on the visibility and openness of the managers. One person told us, "Managers come and go, but I'm not affected by it very much, it's the carers I need to be consistent and they are now." However, one person told us, "I don't know who the manager is I have never meet him or her and I have been here two years." A second person said, "Managers come and go like buses here, it's okay for us but it's the girls [Care staff] I feel sorry for, who leads them, they are like a flock with no shepherd." However, the manager told us they were aware of the views of people and relatives and had written to them introducing themselves and also inviting them to informal evenings to meet them and share their views.

Staff we spoke with echoed the lack of consistency with managers in the home. One staff member told us, "The problem we have is that every new manager is changing stuff and we are struggling to keep up with so many managers and changes." Since the last inspection, the home had a constant home manager in post who left two weeks prior to our inspection. However, the home had additionally received support from the provider's 'Quality Team.' For Autumn Vale this was comprised of a lead manager and two staff who supported homes in times of change. Each of these three staff had resigned since the last inspection. In addition, the regional management structure had changed on numerous occasions, resulting in staff being left with little direction. However, the provider had become more visible within the home, and they had recruited a new regional manager, along with the new home manager. Existing staff had been promoted within the home to senior positions, and these changes were welcomed by staff. With regard one senior staff member being promoted to unit manager staff told us they felt this was a positive move and felt supported.

One staff member said, "[Unit manager] is really helpful to me and I think that by giving them the job it helps us because they know how the company works."

Staff spoken with were all positive about the appointment of the new manager. One staff member confirmed this by telling us, "It is very soon to have an opinion about the new manager, but they are visible on the floor and they talk to us. We have a team meeting next week."

The manager told us they had spent their first week getting to know staff and people, and making their own observations. They told us that they felt there were areas within the culture and team work that required development and planned to hold meetings and discussions over the coming weeks. Staff however had not received regular team meetings with the previous manager to discuss openly among themselves issues relating to the quality of care provided. Staff had not been encouraged to provide feedback or suggest ideas, and other than being informed of the closure of the one unit, were not kept up to date with improvements and innovations within the home, or across other sites operated by the provider. The new manager had already scheduled a number of team meetings with the staff and had prioritised these.

A number of homes operated by the provider in the local area had been found by CQC and the local authority to also not be meeting the required standards. The provider had taken account of these findings and had reviewed the structure and governance of the organisation in response to this, in an attempt to improve the overall monitoring, responsiveness and quality of care at all services, not just in Autumn Vale Care Centre. The provider told us how they had reorganised the senior management team, recruiting new members of the executive board who had specialist knowledge in areas such as clinical governance and accounting.

A new system of reporting from the home manager on a weekly basis had been implemented. This was reviewed weekly by the regional management teams and provider and looked at areas such as staffing levels, safeguarding concerns, incidents and injuries, complaints, development of pressure ulcers, nutrition and medication. The provider attributed to each area a score that was considered the Gold Care average, and any reported area in excess of this figure prompted further investigation by the regional manager. However, whilst reviewing incidents within the home, we identified two occasions where the provider had informed the local authority of an incident that placed a person at risk of harm, but not to CQC as well. The tracker used to monitor the incident had not been updated or had the outcome recorded, meaning that the information reviewed by the senior management team was inaccurate due to the omission of key incidents. The regional manager had identified prior to the inspection that the process for recording and monitoring incidents in the home, particularly safeguarding incidents required strengthening and had introduced a new tracking form to improve this.

Although this new system of reporting gave a robust overview of Autumn Vale Care Centre, we did find that some of the areas were inaccurate. For example, we found that when considering staffing levels, the manager did not assess or include challenging behaviour effectively, meaning that staffing hours for people living with dementia were not wholly accurate. We saw on one unit, that several people required two staff to assist them. There were, with two care staff on duty and a nurse who provided floating support. However, with a staff member required to be present in the communal lounge, and with one person electing to lay on the floor, on this particular day, staff were spread thinly to respond to people's needs. The following day the provider submitted an amended dependency tool they planned to use to review the staffing hours calculated at that time.

We spoke to the provider again on the 20 December 2016 and asked for additional evidence to be provided in relation to staff numbers and the responsiveness of staff when people summoned assistance. As part of

the evidence reviewed we saw that staff responded promptly to call bells and that for the week prior to our inspection, call bells were answered promptly and people did not wait excessive periods for care to be delivered. For this period, the longest people waited for a staff member to respond was three minutes. The further evidence submitted to us demonstrated that as the manager had become more familiar with the needs of people in the home, they acknowledged that the dependency tool used was a numerical staffing tool to approximate staffing levels and they then carried out their observations to verify staffing in the home.

We found that the information in the care plans enabled staff to understand what people`s needs were and how to manage any risks involved. We found that care plans were inconsistent in providing information to staff about people`s likes, dislikes and their preferences regarding the care they needed. For example some care plans had no detail about when people wanted to get up or go to bed, if they wanted their bedroom door open or closed when they were in bed. In other records we found that instructions for transferring people were not always up to date with one referring to using a stand hoist in one section, whilst another section referred to a full body hoist. A second person had lost 3 kilograms within a month, however the review noted, "Good weight gain this month," although they had been appropriately referred to health care professionals and their weight loss was responded to.

Staff were aware of people's needs, and the reduction of temporary staff mitigated the risk of people receiving inappropriate care, but this did mean that an accurate record of people's care needs and preferences had not been maintained. The manager told us that as the care records are continually updated, these areas will be rectified, and we saw in some cases had already done so.

At our previous inspection we found that the service had been without a consistent manager for an excessive period of time, that people's records were not accurately maintained, auditing and monitoring systems were not effective in improving care for people, and staffing levels were not sufficient. At this inspection, where improvements have been found in some areas, there remains further improvement and development required to meet the minimum requirements. The outstanding areas of development within the service, the lack of continued consistency with retaining a registered manager and the apathy felt towards management in the home throughout this report are underpinned by the provider not ensuring a consistent manager had been employed. This meant that the service continued to not be consistently well led and is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had been proactive in supporting the development of the management teams both within Autumn Vale and across their network of homes. They had recently introduced a local managers meeting for the five local Hertfordshire homes. This aimed to provide peer support to the home managers, to share good practice and share ideas together. In addition, a manager's conference had been held for all managers in the organisation to share their views and provide feedback on the organisation. One area noted that had been discussed was about how the provider would better support the managers with future investment. Two new managers had been recently recruited, one at Autumn Vale and another at the home sharing the same site. The induction for managers had been amended to be individual and bespoke for those managers, tailoring training, development and support to the skills and experience of those managers. Further to this we were told that those staff who were in a position of management such as unit leads, deputy managers and registered managers would undergo a bespoke leadership and management course the provider had developed with a training provider, that met nationally recognised standards.

The provider told us, "Both new managers have told us what they expect from both induction and the company so we can tailor the induction to meet those demands now and in the future." It was clear that the

senior management team had reviewed the retention of managers, and were actively addressing how they could retain their services in the future. In addition to this, the provider had brought in additional management support in the form of consultants to support managers with the changes required, and specialist support within the home for areas such as dementia to improve both the care and environment for people.

The provider told us that improvements we found at Autumn Vale Care Centre were being implemented across the homes within their group. They told us that they wanted an overarching culture of care to be delivered based upon their ethos of providing good, high quality family led care. Whilst reviewing the culture within the homes they told us the governance systems used in Autumn Vale would be replicated in each home so that governance, reporting and monitoring was uniform for each home, and meant any identified risks could be responded to by the provider.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) The location had consistently lacked effective management and leadership within the home meaning systems were not consistently operated effectively to ensure compliance. The views and opinions of people living in the service had not consistently formed part of the service delivery plan to improve the quality of care people receive, and people, staff, and relatives did not feel supported by the management team. Auditing and monitoring systems were not consistently effective in identifying incidents or notable events in the home. Staffing levels had not been effectively reviewed and monitored to ensure sufficient staff were deployed, and there remained a lack of appropriate opportunities for people to consistently engage with meaningful activity or social pursuits. An accurate record of people's care needs and preferences had not been maintained that reflected consistently the needs of people at the time of inspection.