Care Quality Commission

Caring Homes Healthcare Group Limited

Rendlesham Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Rendlesham Care Centre provides accommodation and personal and nursing care for up to 60 older people. Some people are living with dementia.

There were 56 people living in the service when we inspected on 4, 10, 15 and 25 November 2014. There are four units in the service, on the ground floor Oak 1 accommodates people living with dementia and Oak 2 which accommodates people living with dementia and who may also require nursing care. On the first floor Chestnut 1 and 2 provide both personal and nursing care.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager in post at the time of our inspection and they told us that they were in the process of completing their registered manager application.

Summary of findings

Prior to our inspection we had received a number of concerns about the service being provided. This included relatives, staff and visitors to the service. For some of these we made referrals to the local authority who are responsible for looking at safeguarding matters. Once we have received the outcomes for all of these we will make a view on a regulatory response. The Commission is aware of an incident that took place in the service in August 2015. We will report on this once our enquiries are complete.

There were systems in place which guided staff on how to safeguard the people who used the service from abuse. Staff understood the various types of abuse and knew who to report any concerns to. When concerns had arisen actions had been taken to improve the service. However not all concerns had been appropriately reported to us.

There were not sufficient numbers of staff to meet people's needs safely and ensure their needs are met in a timely way. In addition some people wanted more social contact with staff. Staff were provided with training and support to meet people's needs and had good relationships with people. However these relationships were hindered due to the staffing numbers.

People or their representatives, where appropriate, were involved in making decisions about their care and support. Improvements were needed in how people's needs were assessed, planned for and met to ensure that they are provided with personalised care which meets their needs at all times.

The service was up to date with changes to the law regarding the Deprivation of Liberty Safeguards and referrals had been made to the local authority where needed. However, the arrangements in place to ensure that the right safeguards were in place where people needed to have thier medicines given covertly, for example within food were not always in place.

People were supported to have sufficient food to maintain a balanced diet. Their nutritional needs were being assessed and met. Improvements were needed to ensure that records of people's fluid intake are accurately documented to demonstrate they were being supported to be hydrated which also helps support wellbeing overall.

Procedures and processes were in place to guide staff on how to ensure the safety of the people who used the service. These included checks on the environment and risk assessments which identified how the risks to people were minimised.

A quality assurance system had been recently introduced but was not yet embedded in practice or fully developed. Systems had not yet enabled the service to independently identify the shortfalls seen at this inspection and improvements seen at our last inspection in November 2014 had not been sustained.

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?
The service was not consistently safe.

Improvements were needed to ensure that all safeguarding concerns are reported appropriately.

There were not enough staff to meet people's needs. Checks on new staff were undertaken to ensure that they were suitable to work in the service.

Improvements were needed in the service's medicines processes and procedures.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff were trained and supported to meet the needs of the people who used the service. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and implemented. Improvements were needed in how people were provided with their medicines hidden in food.

People's nutritional needs were assessed and they were supported to maintain a balanced diet. Improvements were neededto ensure the service could demonstrate people are supported with their hydration needs.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with respect and had caring relationships with them.

Were possible people were involved in making decisions about their care and these were respected.

Good

Is the service responsive?
The service was not consistently responsive.

Improvements were needed to demonstrate how people's wellbeing and social inclusion was assessed, planned and delivered to ensure all their needs were being met.

Not all complaints had been investigated, responded to and used to improve the quality of the service.

Requires improvement

Is the service well-led?
The service was not consistently well-led.

There was not a registered manager in post. There was a new manager in the service.

The service had not sustained improvements made since their last inspection.

Requires improvement

Summary of findings

The service had a quality assurance system designed to identify shortfalls and improve the service. However these systems had not independently identified shortfalls.

Rendlesham 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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4, 10, 15 and 25 November 2015 and was unannounced. The inspection team consisted of overall of five inspectors, a pharmacy inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service. The expert by experience had experience of older people and people living with dementia. The specialist advisor had experience in nursing care.

We reviewed previous inspection reports to help us plan what areas we were going to focus on during our inspection. We also reviewed other information we held about the service including notifications they had made to us about important events. We also reviewed information sent to us from other stakeholders for example the local authority and members of the public.

We visited on different days and at different times because of concerns that had been reported to us about the numbers of staff on duty at different times and about the quality of care provided. On the first day of our inspection on 4 November 2015 we spent time in all of the service's four units, looked at care records and spoke with people, relatives, visitors and staff. On 10 November 2015, we looked at records such as the service's quality assurance and staff training and recruitment. On 15 November 2015, we checked how many staff were working and if people were provided with the care they needed. This was because feedback from people's relatives told us that the service was not fully staffed at weekends. Our visit on 25 November 2015 included checking that medicines were managed in a safe way.

We spoke with 25 people who were able to verbally express their views about the service and 11 relatives/visitors of people. We used the Short Observational Framework for Inspectors (SOFI) on 4 and 15 November 2015. This is a specific way of observing care to help us understand the experiences of people. We spent time on each of the four units in the service and observed the interaction between staff and people living in these units.

We spoke with 17 members of staff, including two members of provider's senior management team, the regional manager, the manager and care, nursing and activities staff. We also spoke with a visiting health professional and asked the views of stakeholders who commission care with the service. We looked at records in relation to 13 people's care, 12 medicines administration records and other documents relating to the management of the service including staff recruitment and training files, and systems in place for monitoring the quality of the service.

Requires improvement

Is the service safe?

Our findings

People's relatives told us that they felt that at times there were not enough staff to meet the needs of their relative in a timely manner. One told us that the service was, "Grossly understaffed." Another said that they felt that the staff were often, "Overwhelmed," by the numbers of people they were required to support and the call bells to respond to. Another person's relative commented that they felt that the staff were under pressure and that there was a high turnover of staff, "[Person] needs more help than [person] gets." Another commented, "They don't seem to have enough staff here, when I am here I never see a carer coming into the room."

People described how staff met their basic care needs but also commented that staff were not always able to spend any extra time with them. One person commented, "I like staff coming in [to their bedroom], and to talk to me…but I think I don't want to take up their precious time, I like talking to people." Another said, "Staff not given enough time with people. Can feel rushed when they are helping me," and, "Only snag is the delay using the buzzer is the time the carers come. It is not their fault they are engaged elsewhere. But it can cause anxiety when you have to wait. Sometimes people [staff] pop in and explain. But if it is only one person they can't just leave that person to come and see me." One person told us that they, "Pressed my alarm when I fell [staff member] came straight away... Would like the staff to stay longer as I enjoy the company."

We saw examples were staff were not deployed in the numbers needed to meet people's needs in a timely manner. For example one person had to wait for 25 minutes before they were supported to use the toilet. This was because there was only one staff member available when they asked and they needed to be supported by two. The other staff working on this unit, Oak 2, were assisting other people to get up.

People were left for long periods of time with no staff interaction. This resulted in people either being disengaged and withdrawn from their surroundings, or unable to get a response to their questions. For example one person in Oak 2 could not find their bedroom and called for help saying, "Don't know where I am now," but there were no staff present to assist them. They entered another person's bedroom and became distressed when they saw another person in the bed (which they thought was theirs). Care records identified that the person did go into other's bedrooms, and an entry in their records in September 2015 identified that a GP had suggested that the person may need to be monitored by staff constantly.

During one shift there were only two staff on one unit, Chestnut 1. One senior staff member and a new staff member (who were on their induction) were working with twelve people. The new staff member had not yet received their full moving and handling training. There were seven people on this unit who required the assistance of two staff members to mobilise. We spoke with the manager about this and they went to check the staffing levels. They advised that two staff from another unit, Chestnut 2, could assist if this was needed. We were concerned that this arrangement could lead to a risk of people not having their needs met promptly. There were other examples where we saw that staff were not available to support people in a timely way. One person was given their breakfast in Oak 1, but had to wait for 10 minutes before a staff member returned and provided them with a plate guard to enable them to eat their meal in a more independent and dignified manner. This was because the staff were busy assisting other people to get up and answering call bells. Further to this a staff member had put two people's porridge to one side to allow it to cool down, they were then called away from the dining area. The people were left waiting 40 minutes before someone came back and served them their breakfast. We also noted that there had been incident reports in August 2015 showing that two people had pressed the 'crash' (emergency) call bell because they wanted their breakfast and had been waiting longer than they wanted.

Lack of staffing also meant that administration of medication did not always take place in a safe, timely and organised way. We saw a nurse on duty who was called away from the medicines administration round on the first floor to attend to an incident on the ground floor. This resulted in them being later starting the medicines round. We also saw two senior staff, one on the ground floor and one on the first floor, were also called away from the administration of medicines several times to answer telephone calls and organise appointments. This meant that the medicines round took up to two hours to complete and demonstrated that staff were not able to soley concerntrate on this important task without being distracted by other matters. There was a risk that late administraton of medicines could mean that people did

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not receive their medicines in a timely way or with a safe gap between doses. For example one person was due to take medicines prescribed to be given at 11am. At 11.20am we pointed this out and it was administered.

Staff told us that they felt that there were not enough staff to meet people's needs. Records showed that two staff members had discussed their concerns during recent supervision meetings. Staff commented to us that they felt lack of staffing meant, "[We] can't encourage as much we should during meal times as so busy." Another told us that there was, "Not enough staff to meet people's needs. It impacts on daily living skills and promoting their independence." Staff also told us that they felt that although they met people's basic needs they did not always have time to support people with their daily living in between support with personal care. For example one staff member said, "It is a struggle to have quality time with people as very focused on the jobs that need doing. Not always meeting emotional needs of people. Would love to sit and chat with them and calm them down but can't if someone is sitting on a toilet and needs my help," and, "... it impacts on the quality of care provided. It is a rush job. Limited interaction which is not ideal for people with dementia. Very task led. Jobs get done but without the interaction and one to one care that people need."

The managers used a dependency planning tool to assess the levels of staff required to meet people's needs safely. This dependency tool showed that the current staffing levels in the service as being appropriate. However, this did not match our observations or what people told us.

The management team told us about the strategies they were undertaking to maintain their staffing levels, including raising the hourly pay rate for nurses. They were also in the process of reintroducing the 'hospitality service' (dedicated staff who serve and support people with meals) at mealtimes to make sure that there was always someone additionally available to serve meals. This meant carers would not be taken away from providing direct care to people because of serving meals. This was confirmed by a staff member who told us, "There is talk about them [provider] getting someone in to do hospitality in the morning that would help us. Free us up to assist people properly." Four potential domestic staff were being interviewed on the last day of our inspection visits. The service had developed their own SOFI tool, which had not been used but may have been useful to use to assess if the staffing levels were appropriate to meet people's needs.

This is a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were satisfied with the arrangements in place to make sure that they took their medicines. One person said, "They [staff] help me with my pills, they tell you what they are giving you." Another commented, "The nurse gives me my inhaler when I need it." Another person told us, "I have so many pills to take I need their [staff] help." We saw that the staff administering medicines were patient and explained to people what their medicines were for.

There were clear systems and processes of ordering and receiving medicines. Administration was recorded clearly on medicines administration records (MAR) charts which were provided by the pharmacy. Some improvements were needed to ensure that clear records and actions were available to demonstrate safe administration. We found that a syringe driver that was to be administered over 24 hours had on one occasion been administered over 33 hours. There had been a problem with the driver and it had not been addressed in a timely manner. MAR charts also contained a code that was not defined, it was being used for the administration of nutritional supplements and it was unclear whether the person was receiving these as prescribed. If there was a choice of how much medicine to give, it was not always documented on the MAR chart the amount people had received. Any handwritten additions or changes to the MAR charts had not always been checked by another member of staff. The balances of medicines in stock did not always correlate with the administration records recorded by the home and in some cases balances were not recorded at all. There had been a recent incident where a medicine had gone missing.

Medicines were stored safely and securely, in locked medicine trolleys or cupboards within a secure treatment room. Medicines that require additional controls because of their potential for abuse (Controlled drugs) were stored securely. A regular check of these medicines by staff was not taking place and the home's policy did not stipulate how often these checks were to occur. Liquid medicines did not always have the date of opening on them and in one

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case an oral solution which needed to be used within three months of opening was still in use nine months later. Eye drops were not always clearly labelled with their date of opening; they should be replaced every month. Medicines requiring cold storage were kept within a locked monitored refrigerator in the treatment room.

Some people were receiving their medicines in a covert manner. Covert administration of medicines may take place when a person regularly refuses their medicine, but they lack the capacity to understand why they need to take the medicine. Covert administration can include the crushing of medicines and adding them to food or drink. Procedures in place to protect people being given their medicines in a covert manner should involve consultation with a pharmacist. It was not always clear that a pharmacist had been involved and some of the covert documents were no longer relevant and should have been reviewed to avoid any confusion.

Staff told us and records confirmed that they had received training in safeguarding adults from abuse. Staff understood policies and procedures and their responsibilities to ensure that people were protected from abuse. They explained various types of abuse and knew how to report concerns.

There were systems in place to identify, report and act on concerns about people's safety. However, we noted that safeguarding referrals had not always been made where required. For example, a relative had raised concerns but this had not been reported to the local authority safeguarding team and had been investigated by the service with no outside guidance, support or input. A recent safeguarding referral made by us following information from a relative and also by another professional was found to be substantiated by the local authority. Discussions with the manager and records showed that actions had been taken to reduce the risks of a similar incident happening. This included a review of the service's falls policy and procedure and the staff were advised of their responsibilities. The service had also sent the person's relative a letter of apology using their own duty of candour procedures.

There were systems in place to identify and reduce the risks to the people. People's care records held risk assessments which identified how the risks in their daily living, including how they mobilised, were minimised. Where people were at risk of developing pressure ulcers, actions were taken to reduce these risks. Records showed that people were supported to regularly reposition. There were also risk assessments in place relating to the environment, including the use of the balcony on the first floor, the garden and the service's transport.

Improvements were needed in how activities were risk assessed and the guidance in place for how these risks were minimised. The activities coordinator told us that risk assessments were in place for outings. However they were only able to tell us the safety measures in place for one in-house activity, which was not documented. The activities coordinator and the manager assured us that the risk assessments for activities would be done to ensure that potential risks were assessed and measures were in place to reduce them. This included considering there may be different risks depending on people's needs, for example dementia or frailty.

Records showed that checks on the safety in the environment were regularly undertaken and any issues that needed attention were addressed in a timely manner. Regular checks and services were completed on equipment including electrical equipment, hoists and the passenger lift to make sure they were fit for purpose. Checks of the service's vehicle ensured that it was safe for people to be transported in. Regular fire safety checks were undertaken to reduce the risks to people in the event of a fire.

We saw that action was taken to reduce risks relating to clinical waste. On the first day of our inspection it was reported that the clinical waste bins had not been emptied. A member of the provider's senior management team made telephone calls to get this addressed. On the final day of our inspection the bins had been replaced with larger ones and notices were posted on them to remind staff to ensure that they were locked at all times.

Records demonstrated that checks had been undertaken on prospective staff members before they were employed by the service. Staff confirmed these checks had been made and they had attended an interview before they were allowed to start work. Records confirmed that interviews took place and their answers to pre-planned questions were scored on their suitability to work in the service.

Requires improvement

Is the service effective?

Our findings

The service was not always consistent in its approach to demonstrating that people were provided with sufficient drinks to minimise the risks of dehydration. One person's relative commented, "My [person] is dry, [person] needs mouth care and encouraged to take sips of water. This doesn't happen at night." We saw that one person in their bedroom did not have a drink to hand. A staff member told us that they always did and they used a specialist cup to maintain their independence. They checked and found that the person did not have a drink and took action immediately to get their cup and drink. We found that records which were kept to monitor how much people had to drink each day were not totalled. Therefore even though records were maintained to monitor people's fluid intake when they were at risk of dehydration, they were not fully completed to allow this to be effectively monitored. For example one person's fluid chart showed they were recorded as having drunk 1,180 mls [which had not been totalled on the sheet] in a day. When we asked a staff member how much they were assessed as needing, they told us two litres. There was no recorded action taken as a result of the shortfall. We then went through other fluid charts with the staff member who again could not explain what action had been taken to address the shortfall. They did however explain that the importance of ensuring records were completed had been discussed at recent staff meetings. The staff member said that they felt that people were being offered drinks but the records were not being completed. However, we could not be assured that this was the case.

People told us that they were provided with choices of food and drink and a balanced diet. One person said, "The food is as good as most hotel foods." Another person commented, "Very good food, the food is always very good." One staff member told us that the catering staff were provided with a list of people's dietary needs and any fortified supplements people needed to maintain a healthy diet. One person's relatives commented that food was, "Always on offer, nice food, homemade, tailored to the individual." They said that they felt that staff had listened to them with regards to the food their relative was provided with.

Where one person had not eaten much, staff encouraged them to have something else, on offering them a yogurt, they said, "Try it, if you don't like it it doesn't matter." The person then ate the yogurt and said that they liked it. The mealtime experience could be improved, for example we saw that people sitting together at tables were served with their meals at different times, one person had not been served their meal and the other two sitting at the table had finished theirs. One person's relative reminded staff that their relative had not yet been served their meal when others were eating their dessert. These were missed opportunities for people to have a more pleasurable and social mealtime.

Where concerns were identified regarding people's nutrition referrals had been made to the appropriate professionals including a dietician and speech and language therapist.

People's experience of support with healthcare varied. One person's relatives told us that their relative had been supported to see the dietician after they had lost weight when in hospital and this had improved since they had returned to the service. However, other examples showed that action was not always taken in a timely way. A recent safeguarding investigation found that a person had not received the medical assistance they needed in a timely manner, resulting in pain and discomfort prior to the treatment they needed. Action had been taken to reduce the risks of this happening again. Another person shared with us that they were still in pain and discomfort from a fall (although they had seen a GP). The manager said that they would seek a further examination to explore this.

People told us that they felt that the staff were competent in their role. One person told us, "They [staff] are very helpful." A visiting health professional told us that they felt that the staff were, "Well trained." One person's relative commented that not all staff used English as their first language which was sometimes a problem. The manager shared examples of how they had arranged English lessons for a staff members to assist them to communicate with people and colleagues.

There were systems in place to provide staff with the training, support and ongoing development to meet people's needs effectively. Staff were encouraged to achieve industry recognised qualifications and the service had introduced the new care certificate into the service during staff induction. This ensured that all staff understood their roles and the what was expected of them.

Requires improvement

Is the service effective?

Staff told us that they felt supported in their role. They were provided with one to one supervision meetings in which provided a forum to discuss the ways that they were working, receive feedback on their performance and to identify any improvements, such as training, required to improve their practice. However, there had been some gaps in the supervision and staff fed back to us that this was because they were too busy. The manager showed us records of supervision plans and assured us that these meetings were back on track to make sure that staff were adequately supported to meet people's needs effectively.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decision, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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). We checked whether the service was working within the principles of the MCA.

People told us that the staff asked for their consent before they provided any care or treatment. This was confirmed in our observations, staff sought people's consent before they provided support to people and they acted in accordance with their wishes. This included if they needed assistance with their food, personal care and where they wanted to spend their time.

Records and discussions with staff showed that they had received training in MCA and DoLS. Staff had an understanding of DoLS and MCA and had completed a number of referrals to the local authority in accordance with guidance to ensure that restrictions on people were lawful. However, records showed and the manager confirmed that DoLS referrals had not been made regarding when two people were provided with their medicines hidden (covertly), for example in food. This had also not been fully explored in people's care records. The manager told us that they would look into this.

Signed documents were in place to show people had consented to their care and treatment, including having a flu vaccination and bed rails. Care plans for people who lacked capacity, showed the arrangements in place for decision to be made in their best interest in the areas that they lacked capacity.

Good

Is the service caring?

Our findings

All of the people we spoke with told us that the staff were caring and treated them with respect. One person said that the staff, "Greeted with goodness, kindness and compassion. Majority of both male and female carers are excellent. All the staff are ever so understanding." Another person said, "[Two named staff] are lovely carers, take an interest in me…carers are very caring made me a lovely cake for my birthday." One person's relative said, "The staff are all very good." Another person's relative commented, "Everyone from when we walk into the home, greet you, know you homely feel. More of a family feel." Another said, "Lovely carers in [unit] very caring and helpful." Another relative told us, "All the staff acknowledged us when we first came here made us welcome it gave a strong impression and that's why we chose this place. Not changed since… staff are kind and patient and look after all [person's] needs." A comment made in a website designed for people to add their views about care services, stated, "Lovely staff, always able to speak to." Another commented, "Lovely kind care assistants and RGNs." A visiting professional told us that the staff were, "Charming and lovely."

There were many examples we observed that the staff treated people in a caring and respectful manner. Staff made eye contact and listened to what the people were saying, and responded accordingly. A person talked with staff about the recent events in the news and their feelings about this. Another staff member had brought in a book from home after identifying that the person had picked this book up and talked about it in a recent visit to the doctor's surgery. When a staff member provided a person with their medicines, the person laughed and said, "What have you got for me today?" They then went on to call their different tablets fruits and cocktails, which led to a discussion about what they were, both the staff member and the person were laughing and this was clearly a regular interaction.

Whilst staff were clearly willing to engage positively with people often, these interactions were cut short due to staff being busy supporting other people with their care needs.

The staff's approach to ensuring people's privacy, independence and dignity was promoted and respected was varied. We saw some good practice but also saw examples where staff discussed who they were assisting to get up next in front of other people. The manager told us that they had sourced dignity training for staff to address this issue which they had also identified. We also saw one person's bedroom door had a sign saying it should be kept closed at all times, but the door was open.

One person's relative told us that they were attending a care review in a, "Couple of weeks," to discuss their relative's needs and any changes. This helped them to have an input into maintaining their relative's choices. A letter sent to the service from a person's relative also commented on how the service had listened to their views, "Thank you for following up so diligently on the actions coming out of the review of my [person's] care plan. It has made a big difference." Another person's relative commented that they had completed a document about their relative's history and experiences, as a result the staff knew the person well and were able to engage in discussions, for example in the person's love of an animal. Another person's relative said "I suppose I would like to be more involved so I know what care is in place. They do ring me to say if anything has happened."

People told us that they could have visitors when they wanted to and this was confirmed by people's visitors. This ensured people were free to continue to enjoy friendships and relationships with those they cared for after moving to the service. This helps to reduce the risks of isolation and loneliness.

People's care records included their likes and dislikes, preferences about how they wanted to be supported and cared for and their decisions about end of life care. One person said that it would, "Be better if the carers were all the same get used to my routine."

Staff spoken with and our observations showed that they were knowledgeable about the people they supported and their life experiences. One person's relative said, "[Person] is fond of the night carers they understand [person], know [person's] likes and dislikes." One person told us about how their choices were respected "I love it here, you don't have to do anything, sleep when you want to, stay in bed when you want to, you can just lie here and they [staff] do everything for you".

People's care plans included information about people's personal history and their diverse needs and how these needs were met. This included how they communicated, mobilised and their spiritual needs.

Requires improvement

Is the service responsive?

Our findings

People's care plans were inconsistent and contradictory in some areas. There was also a lack of detail about how staff should approach people's individual complex care needs. For example, one person's care profile stated that they were unable to determine when they needed to use the toilet, but their daily living skills stated that they were able to recognise their need for the toilet. Another person's care records stated that they required a sugar fee diet due to their diabetes. However, in another part of their care records it stated that they were to have, "Not too much sugar." It was not clear how much sugar this person could have and was not clear about how the person should be supported appropriately. Another person's care records stated in one part that they were nursed in bed and in another part that they sometimes got up. There were also references of them being, "Aggressive," but there was no detailed guidance about how they displayed this behaviour, how they should be supported to reduce their anxiety and any potential triggers. Without clear information there was a risk people could receive inappropriate care or care that was not personal to their needs.

There was limited consideration given to how the needs of people living with dementia were assessed, planned for and met. One entry stated, "Requires 1 – 2 [staff] to help, depends on how I am feeling," but there was no further information for staff on how to recognise when this was needed. The record also stated, "I sometimes have behaviour that challenge at care intervention so staff to monitor this and ensure my needs are met with dignity and privacy," but there was no further information about possible triggers and what types of behaviours the person had. There was also limited reflective practice and reference to how people were supported to reduce their anxieties, what might be working well or what should be avoided.

We were concerned that records did not show if staff had escalated concerns. For example one person's daily records in November 2015 stated, "Says not well…seems well no concerns." There was no further information to show if this was referred to a member of the nursing staff or another health professional. Daily records tended to be task led rather than the actions staff had taken to support people's wellbeing, including their social and emotional as well as their physical.

Information about people and their care needs was not always up to date or available. One person (who started using the service in September 2015), had no care plan or risk assessments in place to show how the person's care was assessed, planned and met. There was a photograph of an injury in their records but there was no guidance for staff or evidence to show how it was to be treated. The daily records indicated in some entries that the person's care had been provided and referred to the numbers of care plans in place, which were not there. There were further examples where people's care plans had not been fully completed or reviewed effectively. Despite a person having recent falls, their falls care plan was only partially completed and had not been thoroughly reviewed since May 2015. Another person who was at risk of developing pressure ulcers had signs of these developing. However, their skin viability care plan had not been reviewed to reflect this and the current level of risk was not noted. We discussed this with the registered manager who told us they would immediately make sure that the missing information was completed so staff could access up to date care plans.

We showed the manager all of these examples. They were not aware that the records were not in place. However, they took prompt action and addressed this, by completing the relevant care plans and risk assessments. This minimised the risks continuing.

This is a breach of Regulation 9: Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite shortfalls noted in care planning and records people who were able to tell us their view told us they were happy with the care they were provided with. One person said, "On the whole I am happy with everything." Another person commented that they were, "Up out of bed at 8am. I have a cup of tea first then a carer comes and helps me wash. They know my routine and how I like things done but they are pushed for time. Can feel it is rushed. They [staff] try ever so hard, very hard working, very patient." Another said, "Place is second to none am treated very well." One person commented, "I am very well looked after nearly all of my needs are taken care of. It is a very easy lifestyle."

Requires improvement

Is the service responsive?

Staff spoke with us about how they provided care and the support that people needed. They were interested in people's lives and how they could help more. One staff member had come into work specifically to support a person with a health care appointment in the community. Another staff member explored the idea with a person that a talking watch might help them to tell the time when they were not in their bedroom with their talking clock. This person told us how they had been assisted to source talking books which they enjoyed along with listening to music.

There were activity plans displayed in each of the four units. Records were kept which identified what activities each person had participated in and when they had declined. These included both group and one to one activities. Feedback from people and their relatives about the activities on offer varied for those who were living with dementia. The minutes from a relative's meeting in September 2015, included that the activities were described as, "Erratic," they were reassured that the activities provision for the units caring for people living with dementia were being developed. One person's relative said they felt that the activities were more focussed, "For upstairs," however, they were seeing improvements in the provision for people living with dementia and they were, "Now seeing more." They said that the activities coordinator had supported their relative with one to one time and that if the families missed any entertainment this was made available on video for them to watch. One person's relative said that they had, "Heard about the activities never seen the activities person down here [ground floor]." Another commented, "Would like more activities the coordinator is mostly upstairs."

One person told us how they like to read a newspaper, "I read for a long time, only way I know what is going on," they also said they liked to listen to the radio. Another person commented that there was, "A nice enclosed garden, we go out there on the odd occasions but it is difficult to get to," this person lived on the first floor of the service. Another said, "There is a nice balcony which we go out on when it is warm." Another commented, "I like my own company and room. Don't want to go out. Be nice if the carers I like could talk to me more. I find things I like to occupy me like puzzles, knitting and books." One person told us that they chose not to join in activities because most were traditionally female orientated and would prefer something like a game of darts.

Two relatives told us that there was a facility in the service where people could purchase items, such as snacks, which they said this was, "Very good on a day like today, it is cold and miserable." A staff member told us that this had started in April and any profits were used to fund things such as fish and chips at a local seaside town.

People knew how to complain and were able to share their experiences with staff if they were unhappy. They told us they were comfortable speaking with staff if they needed to make a complaint or raise a concern. One person's relative said, "[Staff] keep me informed of what is going on. They know the care arrangements and talk to me if something is amiss. If I had a problem would go to them. Never had to…Happy with the care here." Another person's relatives told us that they had not been previously, "Confident," that their concerns were acted on but they now were. They commented that, "[Manager] has started a little box," where they could write good or bad comments, "Just to draw to [manager's] attention." One person told us that they had made a complaint previously and felt that this was addressed to their satisfaction. We saw that where something had gone wrong the provider had written to the person concerned and apologised under there process for ensuring they complied with Duty of Candour.

Despite this good practice the approach was inconsistent. There were three complaints for 2015 which did not have any information about how they had been addressed. The regional manager showed us their quality assurance system for one of these complaints. A letter had been sent to the complainant advising that their concern was being investigated but there was no further contact made. The nature of the complaint had not been accurately recorded on this system and the provider's own systems in place for monitoring complaints had not been effective in identifying that the complaint had not been fully addressed. Concerns received from people's relatives identified that verbal concerns and actions taken had not been recorded. To address this, the manager showed us a new system which had been introduced in order to capture verbal concerns and actions taken to address them.

Requires improvement

Is the service well-led?

Our findings

There was no registered manager in post, the previous registered manager had submitted an application to cancel their registration with us in September 2014. Since the our inspection on 17 November 2014 there had been three managers in post, which had not provided stable, consistent and structured leadership for staff. This was reflected in the rise of comments and concerns we had received about the service in the last year. A new manager had started working in the service in August 2015. They told us that they were in the process of submitting their registered manager application to the Commission.

The service was inconsistent because not all of the systems and processes in place were working effectively to provide a safe and good quality service.

The regional manager showed us their computerised quality monitoring system which allowed the analysis of incident such as weight loss, falls, pressure ulcers, deaths and accidents. Incidents were monitored and analysed to check if there were any potential patterns such as risk areas or times (for example at night) which might be a factor. An action log in place helped to monitor the improvements made to reduce further risks. However, we saw that this was not used to its full potential because the concerns we highlighted such as inadequate staffing levels, missing and incomplete care plans, the lack of monitoring that demonstrated people had enough to drink, use of convert medication, responses to complaints and best practice, policies and proceedures that needed reviewing (Medication had not been reviewed since March 2014) had not been identified. The system was new and had not yet become embedded in practice. The management team were positive that this would develop and assist to monitor and analyse any issues which had an impact on people's wellbeing.

Despite this the provider has failed to sustain improvements made in their last inspection in 17 November 2014 following our concerns during the previous inspection of 23 and 25 June 2014. For example, documentation of care, people not being provided with the support they needed in a timely manner and quality assurance.

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

People and relatives told us that they were confident that the new manager was making improvements in the service. One person's relative commented that it was, "Very early days," with the new manager in post but they had noted an improved, "Feel in the home." They also said that the manager was, "Visible, door is always open, also very good at coming in here [lounge] and talking to people." A recent comment made about the service was, "For the last three months, under the new manager everything is improving. The new manager works relentlessly and it is now a very caring home. There is very good teamwork and the staff like the manager. She is popular with the staff, residents and friends of the residents and consequently there is a very happy atmosphere here."

Discussions with the manager and a member of the provider's senior management team showed that they understood their roles and responsibilities in delivering quality care to people which was safe, effective, caring, responsive and well-led. The manager responded positively to all our requests, was open to feedback and took immediate action where appropriate. The manager reported they were new in post, recognised there was work to be done to improve the home, and that they had found senior management supportive.

Staff felt that the manager was approachable. They were positive and understood their responsibilities in providing a good quality service to the people who used the service. One staff member said, "I can go home and sleep as I know I have done the best I can do even though I can't do as much as I would like to do. We do the best we can with what we have got. There are good seniors in place."

The manager told us about the staff meetings they had held with an aim to reassure staff about the changes in management and the ongoing planned improvements. They said that this was positive and that the staff were receiving these well. Records confirmed what we had been told.

Minutes from meetings attended by people and their relatives showed they had the opportunity to express their views. This was confirmed by a person's relative who told us that they regularly attended and was kept updated with changes in the service. One person's relative commented

Requires improvement

Is the service well-led?

that they had attended a, "Residents meeting a few weeks ago," they had made a suggestion of putting people's memories around the lounge area, which would give staff a talking point with the people and learn more about them as a person. They pointed to the glass/wall section where they were displayed. "Did act on that straight away"

Records showed that actions had been taken as a result of comments made in satisfaction questionnaires completed by people who used the service and their representatives. We saw letters and cards thanking the service for the care and support provided. In addition to this people had put comments on a website designed for people to comments about care services. These were mainly positive. However, where concerns were included the service had responded and advised of what they had put into place to improve people's experiences.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with safe care and treatment. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care records of service users were contradictory in parts and did not show that their care was assessed, planned and delivered in a way which met their individual needs. Regulation 9 (1) (a) (b) (3) (b) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of staff to meet the needs of service users. Service users were not provided with safe care and treatment. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place to assess and monitor the service provided is not robust enough to identify shortfalls and to sustain improvements made. Regulation 17 (1) (2) (a) (b) (c) (f)