Amore Elderly Care Limited

Amberley House Care Home - Stoke-on-Trent

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 23 May 2018, with an announced follow up visit on the 24 May 2018. At the last inspection completed on 7 March 2017 we rated the service Requires Improvement.

At this inspection we found improvements had not been made and the provider was not meeting the regulations for staffing, safe care and treatment, and governance arrangements. You can see what action we asked the provider to take at the end of this report.

Amberley House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Amberley House Care Home accommodates up to 71 people in one adapted building. At the time of the inspection there were 62 people using the service.

There was not a registered manager in post at the time of our inspection. 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.

People were not supported by sufficient staff to meet their needs. Risks to people's safety were not always planned for and staff did not always follow guidance to keep people safe. People were not always safeguarded from potential abuse. Governance systems were not always effective in identifying concerns and driving improvements.

Staff had received training, however further work was required to ensure this was kept up to date and staff competency was checked effectively. Improvements were needed to ensure the environment was suitable for people living with dementia. People did not always receive consistent care.

People received support from staff that were caring, however improvements were needed to make sure that this was consistent. People's preferences were not always understood by staff. People were not consistently supported to follow their interests or religion.

People were not always supported to have maximum choice and control of their lives and staff were not always aware of how to support them in the least restrictive way possible; the policies and systems in the service were not always supportive of this practice People were not consistently supported to meet their dietary needs. People were not always supported to make decisions and their communication needs were not always met. People were respected, however sometimes care was received that was not always dignified.

People were supported to take their prescribed medicines. People were protected from the risk of cross infection. Staff were safely recruited. People were supported to maintain their health and well-being.

People were supported to identify how they wanted to be cared for at the end of their lives. People understood how to make a complaint and these were responded to and used to make improvements.

Notifications were submitted as required and the manager understood their responsibilities. We found people; their relatives and staff felt supported by the manager and were able to be involved in their care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not always receive support from sufficient staff. People were not always supported to manage risks to their safety. Risk management plans were sometimes not in place and staff did not always follow plans. People were not consistently safeguarded from potential abuse. People had their medicines administered safely; however guidance for administration was not consistently in place. People received support from safely recruited staff. People were protected from the spread of infection. The systems in place to learn when things went wrong were not always effective.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed and planned for, but improvements were needed to ensure this reflected up to date information and that staff understood people's needs. People were not always supported by staff that had the knowledge required, plans to ensure staff competencies were checked and staff stayed up to date required further improvement. The environment required further improvement to meet the needs of people living with dementia. People's rights were not always protected by staff, as staff lacked knowledge on the principles of the MCA. People's nutrition and hydration needs were not consistently met. People received support to monitor their health and seek advice from health professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by caring staff, but staff sometimes lacked opportunities to engage with people. People were not consistently involved in making decisions and choices about their care and communication needs were not always met. People's privacy was maintained, however people sometimes experienced care that did not take account of their dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always able to follow their interests or spend time doing activities they enjoyed. People's needs and preferences were not consistently understood by staff. People received a response to their complaints. People were supported to consider their preferences for effective support with end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor care delivery were not effective in driving improvement. People and staff felt supported by the management team. The provider notified us of incidents.

Amberley House Care Home - Stoke-on-Trent

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 unannounced inspection took place on 23 May 2018, with an announced follow up visit on the 24 May 2018. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service.

During the inspection, we spoke with seven people who used the service and five visitors. We also spoke with the peripatetic manager, the deputy manager, operations director, quality improvement lead, nine care staff and four nurses.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records of six people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including complaint logs, accident reports, monthly audits, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 7 March 2017, we rated safe as Requires Improvement, this was because risk assessments were not always followed and staff were not always deployed effectively. At this inspection we found the provider had made the required improvements.

People and their relatives told us they did not feel there were sufficient staff. One person told us, "Nearly every day you press the buzzer or call staff and they don't come quickly enough when you ask to go to the toilet, there is always some excuse." Another person told us, "I like to get up early…I'm in the lounge for six in the morning you have to wait until nine for breakfast. There's only one serving so you have to wait three hours." A visitor told us, "There does not seem enough staff, everyone here needs two staff to help them and the lounges are very often unattended, buzzers are responded to quickly, but then you have to wait for 15 minutes for someone to come and help [person's name] with the toilet." Another visitor said, "When we ring the bell, staff come pretty quickly, [person's name] relies on another resident shouting for help if they are in the lounge because [person's name] couldn't use the bell." Staff told us they did not feel there were enough staff. One staff member told us, "We don't have time to spend with people and give them the attention they need." The staff member went on to say that one person who had behaviour which challenged would benefit in how their behaviour was managed if they had time to spend having a chat. Nurses also felt there were insufficient staff. This meant they had to assist care staff, resulting in some of the daily checks on people's care delivery not being carried out by the nurses who were responsible for them.

Our observations supported what we were told. For example, we saw people waited for meals. One person waited for an hour for breakfast, whilst another person waited for an hour for support with their lunch. We saw staff were not offering the encouragement required at mealtimes in line with peoples care plans, this was because they were busy supporting other people. We saw lounges were left unattended, which meant some people were unable to call for help if they needed it. On one occasion there was a near miss incident, where one person almost fell over a cable whilst walking around the lounge. We reported this to the manager, who assured us they would investigate. This demonstrated people were not supported by sufficient staff to meet their needs and maintain their safety. We saw people were left without stimulation which meant they began walking around without staff present to observe if they were safe. We spoke to the operational manager about this, who told us they had a tool in place to assess people's dependency and inform the amount of staff required to meet people's needs. They were unable to provide a copy of the tool at the time of the inspection, and although asked to send this to us, this had not been received. However, following the inspection, the operations manager confirmed they were reviewing staffing levels and had increased staffing for a week and would then reassess the staffing requirements.

These issues constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not always managed effectively, because risk assessments and plans were not consistently followed. For example, one person was assessed as being at risk of malnutrition. There was a plan in place to reduce the risks to the person. The plan stated staff should monitor the person's food intake

and ensure they were encouraged to eat. On the day of the inspection we saw the person was not eating their meals, they received no encouragement from staff and the meal was removed. The person was having their weight monitored, we found the person was continuing to lose weight and no additional action had been taken to address this. This meant the person was at continued risk of malnutrition. We spoke to staff about this and they confirmed they would review the person's risk assessment. Another person presented with behaviours that could cause harm to themselves or others. There had been two incidents of behaviour which had placed another person at risk of harm. Whilst staff had reported these incidents and they had been raised with the safeguarding body and additional staff had been sourced to monitor the person, no guidance was in place for staff on how to deescalate the behaviour, and no plans were present for staff to assess what may trigger the behaviour and monitor the effectiveness of any actions taken. This meant the person may continue to present a risk to other people. We spoke to the manager about this, and they confirmed they would review the person's behaviour plan. This meant the provider did not have systems in place to ensure people were safe from the risk of harm.

There were systems in place to learn when things went wrong. However, we found these had not always considered actions needed to prevent reoccurrences. For example, we found a high number of individuals had experienced unwitnessed falls. The review of the individual incidents had taken place, but it was unclear if consideration had been given to any changes to the way people were supported such as staff numbers and deployment which may have prevented future falls. This meant the provider was not consistently using information to learn and make changes to the service to avoid incidents recurring.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors shared mixed views about how the service kept people safe. One visitor said, "It's generally very safe, no major problems." Whilst another relative told us, "I worry about what would happen if I did not come every day, I don't feel like I can leave [person's name] as they are mostly in their room and could not call for help." Staff demonstrated an understanding of abuse and could describe the signs to look for. We saw where incidents had occurred staff had reported these in line with the policy. However, we found it was not always clear if incidents relating to people being verbally and physically abusive to each other had been reported to the safeguarding team. We spoke to the manager about this, who confirmed that all incidents had been reported since their arrival at the site; however they would check and make referrals for any that had previously been missed. This showed improvements were needed in how incidents which may need safeguarding referrals were monitored, to ensure people were safeguarded from potential abuse and protected from the risk of harm.

People and their relatives told us medicines were administered safely. One visitor told us, "There have never been any problems with medicines administration." Medicines were stored safely. There were lockable trollies and cupboards and when required, medicines were stored in a refrigerator. We found checks were carried out on medicines stock and medicines were ordered in line with peoples prescriptions. We found people had their medicines administered as prescribed and these were recorded on Medicine Administration Records (MAR). We found some people needed 'as required' medicines. Staff had a good knowledge of when to administer as required medicines, however we found protocols were not consistently in place to give written guidance to staff. This meant there was a risk that people may not receive the medicine they needed when they needed it. We spoke to the deputy about this and they made sure the guidance was updated before the inspection concluded. This meant people received their medicines as prescribed.

Staff understood how to minimise the risk of cross infection. The provider had systems in place to monitor the procedures which staff followed. We saw staff used protective clothing and gloves. We saw there were handwashing procedures and gel was available to staff and visitors. However, we did find one cushion which required cleaning. We spoke to staff and the quality manager about this and action was taken immediately. This meant action was taken to minimise the risk of cross infection.

People received support from safely recruited staff. We saw the provider ensured checks had been carried out before new staff started work, which included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with in a care setting.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 7 March 2017 we rated effective as Good. At this inspection we found the service was not consistently effective and improvements were needed.

People and their relatives had mixed views about assessments and care plans. One person told us when asked if they had been involved in their assessment and care plan, that they were unsure if they had one. One visitor told us, "There used to be a photo in the room with information about [person's name] needs and who visits, but it's gone now. I've never seen a plan with anything else about their needs" Whilst another relative told us, "[Person's name] gets very tired so prefers to be in their room. It is written in the care plan that they can only be in the chair for three hours. The staff are very good and stick to it." Staff told us they did not always have time to read care plans and in some cases were unclear why people needed certain support. For example, one person required their care delivered in bed at all times. The care staff and agency nurse were unable to tell us why this was. This meant there was a risk; the person may have been supported out of bed which could have caused them an injury. Some care plans contained information which was out of date and required review. However, there were plans in place to make the required improvements to assessments and care plans. We will check this at our next inspection.

Systems were not always effective in providing people with consistent care. We saw the handover documents in use gave nurses information about people's needs and any monitoring they required. However, staff told us the handover was not consistently clear, in particular from agency nurses. Staff said handovers were sometimes rushed, and they did not have time to follow up and read peoples care plans when things had changed, they simply had to go by what the handover told them. This meant there was a risk people's needs could change without staff being aware. This demonstrates how improvements were needed to provide people with consistent care and support.

People and their relatives said they felt staff had sufficient training. One visitor told us, "Staff appear safe and trained in using the hoist for example." Staff told us they received an induction, which included shadowing another staff member and they had access to ongoing training. We saw records which showed some staff training was out of date, however refresher training was planned. We also found staff did not always demonstrate the knowledge required to provide effective support. Staff were trained in the Mental Capacity Act 2005, but told us they were not really aware of which people were subject to a Deprivation of Liberty Safeguard (DoLS) as they did not have time to review peoples care plans effectively. Some staff told us they were unsure of how to support one person that displayed behaviours that challenged. Staff told us they felt they needed more in-depth training on how to support people with behaviours that challenged. Records confirmed not all staff had received training in this area. We saw staff received supervision on a regular basis and there wre staff meetings in place which enabled staff to be supported. We saw some staff did not appear to know how to engage people with dementia in meaningful activity. We found staff had an induction; however from the records we could not be sure from the records that the provider used the care certificate as part of their induction. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life based on 15 standards to ensure staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and

support. We spoke to the operations manager about this and they told us they were aware that some staff required additional training, in particular around behaviour management and dementia and this had been arranged. They told us staff would begin to receive training in June 2018. We will check progress and the impact of the training at our next inspection.

We found there were adaptations in place to support people with meeting their physical needs for example, toilets and bathrooms were adapted and there were grab rails in corridors. The environment was free from hazards and people could move freely and safely. People were able to personalise their bedrooms. National Institute for Health and Care Excellence (NICE) guidelines state; 'When organising home placements for people with dementia, health and social care managers should ensure that built environments are enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment.' Some doors had signs on to help people recognise the rooms, for example, communal areas and were painted block colours to help with visual identification. However, people's bedroom doors were not personalised to help them identify their personal space. This meant people living with dementia may find accessing some areas in the home difficult.

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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People had their consent sought prior to receiving care and support. We saw staff seeking consent from people and where this was not given, staff withdrew and tried again later. Staff understood consent and could identify where people lacked capacity and described how decisions were made in people's best interests. We saw people had their capacity assessed and there were documented best interest decisions in place where people could not consent to their care. For example, where people were unable to consent to their personal care, a discussion had been held with the person's relatives and a decision taken in the persons best interests about how personal care should be delivered. This demonstrated consideration had been given to the principles of the MCA.

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). Where people were having their liberty restricted an application had been made to the authorising body. However we found staff were not aware of what this meant for individuals. For example, one staff member said, "I know it means they can't go out, but we don't get information about that." This demonstrated staff were not consistently knowledgeable in how to support someone in line with their approved DoLS. Staff required further training and information about this. We spoke to the quality manager and they told us they were going to introduce a system of flash cards to reinforce staff knowledge on this area. We will check the effectiveness of this at our next inspection.

People and their relatives told us people could access health advice when they needed it. One person said, "If you are ill, they call a doctor, they're pretty good at that." A visitor told us, "[Person's name] has an optician appointment soon; they will arrange an ambulance to take them." Other people and relatives discussed how people had support from physiotherapists, chiropodists and opticians. We found people had been referred to appropriate specialists for support with their health and well-being, records showed how the information and advice from professionals was used to direct peoples care and support. This showed people had support to meet their health needs and see health professionals for advice where needed.

People told us they were mostly happy with the food and had a choice of meals. One person said, "There is a choice at breakfast, I only fancied toast today though." A visitor told us they felt the food did not offer much choice for people and they brought things in to supplement choice. Staff understood where people needed a specialist diet provided. Staff described the assessment undertaken for one person that required a speech and language therapy (SALT) assessed diet. They gave us detail about the consistency of food and drinks to protect the person who was at risk of choking. We were able to confirm in the persons care plan this was correct. However, staff were not consistently providing support at mealtimes where people were assessed as requiring encouragement with their meal. This showed improvements were needed to ensure people received consistent support to meet their dietary requirements.

Staff told us people were asked what meals they would like the day before, we saw staff asking people, nobody was shown a menu or anything pictorial to help them decide. We asked staff how people's meals were chosen if they were unable to choose for themselves, and they told us there was a preferences sheet for meals in people's care plans which would be referred to. However, some staff we spoke with were unfamiliar with this and did not know what some people may prefer to eat. We observed people have their lunch. Staff supported one person by crouching down next to them and supporting them to eat. The staff member gave lots of eye contact and smiles and the person smiled back, they were observed chatting and singing to the music with staff whilst eating their meal. However, this was not consistent. One person had a meal placed in front of them, no explanation was given by the staff member as to what the meal was and then the person had a spoon full placed in their mouth. There was no conversation between the staff member and the person throughout the meal. This showed people were not consistently having a pleasant mealtime experience.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 7 March 2017 we rated caring as good. At this inspection we found improvements were required.

People and their relatives told us they felt staff were mostly kind and caring. One person said, "Staff are very good and kind…they chat to you when they are looking after you." One visitor told us, "[Person's name] gets a little stressed when using the hoist, staff talk to them and calm them down." Another visitor said, "95% of staff are kind and respectful. I'm quite happy with them." Staff had variable knowledge about people's needs and preferences. They told us they did not always have time to get to know people well, whilst others were still quite new to the role and they hadn't got to know people well yet. We saw some positive interactions between staff and people. For example, we saw staff say "Hello my friend" to one person and smile at them. The person's face changed expression and they smiled and looked happy to see the member of staff. On another occasion we saw a nurse stroking a person's hand gently whilst explaining what the person's medicines were for. Whilst there were positive warm interactions this was not consistent. We saw one person try to attract a staff member's attention by pulling at their clothing. The staff member turned and looked, but said nothing [they were supporting another person at the time]. The person stated, "I just want help but nobody seems to care at all." The staff member did not respond to the person or offer them any understanding. This showed improvements were needed to ensure people received consistently caring support.

People told us they could choose what they wanted to do for themselves, relatives supported this. One person said, "I choose to have my lunch and tea in my room." Another person said, "The staff asked today did I want to go into the lounge. I said no." The person was asked if they were always given the choice to go to the lounge, they responded, "It depends how busy the staff are." Staff told us people could choose what they wanted to do and where they wanted to spend their time. They told us people had a choice of clothing and meals as examples. We saw people were offered a choice about where to sit and what to do. However this was not consistent, one person told us they wanted to sit in the dining room for their lunch, however nobody was there to take them and now someone else was in their usual space at the table, which meant they would not be able to sit with their friend. We asked staff to come and support this person; however they ended up sat at a table alone for their meal. This showed staff were not always supporting people to maintain relationships which were important to people.

People did not always have support to communicate about their care in a way that was effective for them. Staff told us about one person who could not communicate verbally, they felt pictures may help, but none were provided. In another example, one person's language was not English. Staff had some ideas about support which could be provided to this person, using technology but nothing had been put in place. The only verbal communication possible was when family visited. Staff told us they felt the person may benefit from using technology to assist with translations, however there were no plans in place to address this. This meant the provider had not met the requirements of the accessible communication standards.

People and their relatives told us privacy and dignity was maintained. One person told us, "The staff help me

to shower, I never feel embarrassed." One visitor told us, "Staff support [person's name] in a respectful way, they do not like the hoist and staff do this quickly and smoothly to minimise the person's distress." Another visitor commented, "We are satisfied; the staff are respectful to [Person's name]." However relatives raised concerns about staff not being respectful with people's belongings, telling us things they had purchased went missing from peoples rooms and no explanation was given. Staff were mostly observed treating people with respect, asking for consent and making sure people had their privacy maintained. One staff member was responsible for the phone whilst the nurse was carrying out the medicines round, this rang whilst they were supporting someone, and the staff member was observed shutting the phone off whilst they finished supporting the person. This showed respect for the person they were supporting. However, this was not consistent. We observed some people did not receive dignified support. For example, one person was sat in the lounge with their stockings down around their ankles, staff were unaware of this. On another occasion, we saw staff putting an apron on one person at lunchtime, the person clearly did not want the apron on but staff persisted and put this on anyway, taking no account of the person's refusal. This showed staff were not consistently providing support which was respectful.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 7 March 2017 we rated responsive as Good. At this inspection we found improvements were needed.

People's diverse needs were not always assessed and planned for. One person told us, "Religion is very important to me, I have not been told about a vicar coming in; I would like to talk to someone about it as it helps me." One relative told us, "[Person's name] was very religious all of their life, a very active member of the church. I didn't know there was a service here; I don't know if they have been asked to attend, I don't think they have." Staff told us they didn't always get to know people as well as they would like and would not always know their preferences for things. One staff member said, "It can be hard because you tend to work on one side (upstairs) so you don't get to know the other people. To be honest, when I do the care plan reviews I read the first section and think 'gosh, I didn't know that about that person'; you just don't have the time to get to know people." Another staff member told us, "To be honest we do use a lot of agency staff so they won't know people as well either."
We looked at assessments and care plans and found they were not consistently identifying people's individual preferences. Where this had been assessed and peoples care plans held details about preferences this was not always followed. In particular peoples diverse preferences relating to culture, religion and sexuality were not consistently assessed and considered. For example, religion was documented as important; however despite this no action had been taken to support one person to meet their religious needs. In another example, one person's preferences for clothing were documented in their care plan as always preferring to wear trousers. On the day of the inspection the person was wearing a skirt; staff were unaware of the person's preferences. This meant the person was not supported to wear the clothing they were most comfortable with as staff had not followed their preferences. This demonstrates improvement was required to ensure people's individual preferences were met and they received personalised care.

These issues constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and their relatives told us there was not always much going on at the home. One person told us, "I played Bingo this morning. We used to do much more, but we don't do much now." A visitor told us, "I come every day; it's unusual to have the activities like there are today; we haven't had activities for quite a while." Whilst another visitor told us, "If a singer comes, they will bring [person's name] to the lounge to listen and; a lot seems to happen downstairs rather than up here." The visitor went on to explain the person required a hoist for transfers and they felt this was the reason the person did not get to join in activities downstairs too often. Many visitors agreed there were more opportunities for people to engage downstairs. For example, one visitor said, "They do all of these activities down here [pointing to a notice board] but nothing upstairs. I came on Saturday (Royal wedding) they all had hats on, but nothing happening up here." We spoke to staff about activities and they confirmed sometimes people from upstairs were unable to join in the activities. Most people in the upstairs part of the home were living with dementia. We spoke to the quality improvement lead about this and they told us they were aware improvements were needed to activities and they had plans in place to make improvements. We will check this at our next inspection. Staff told us the

plans for the day which included outdoor activities with plants, colouring and pamper sessions. However, later that day we identified people had chosen to play bingo instead, which staff had put in place on request. This showed when activities were planned they choice was driven by people.

People were asked on admission about their wishes for how they would want to be cared for at the end of their life. We saw plans were put in place which identified people's wishes relating to their preferred location, pain management, treatment and arrangements for after their death. There was nobody receiving end of life care at the time of the inspection. However, staff were able to describe how people would be supported.

People and their relatives understood how to make a complaint. They told us they had raised concerns and these had been addressed. They gave examples of where formal and informal complaints and concerns had been listed to and responded to. We saw records which supported what we were told and showed the provider took action to address people's concerns and responded to them in line with their policy.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 7 March 2017, we rated well led as Requires Improvement, this was because incidents were not always investigated and there was no system in place to ensure risk assessments were followed. At this inspection we found the required improvements had not been made.

Accidents and incidents were monitored and analysis was completed, however it was unclear if consideration had been given to any patterns with incidents. The accident investigation records showed a number of these accidents were unwitnessed falls. Investigation records did not demonstrate that consideration was given to wider factors which may have led to the fall. For example, we identified a greater number of falls were occurring between 8pm and 8am, rotas confirmed staffing levels were lower during this time period. We could not determine from the accident investigations or analysis we saw, whether this had been considered. This meant we could not be assured analysis was identifying areas for action to avoid future incidents.

The operations director and manager told us there was a dependency tool in place which was used to identify the number of staff hours that were needed to meet people's needs. However, we found people were not having their needs met at the times they needed it. Insufficient staffing levels were resulting in people getting undignified care and staff were not always able to get to know people well or provide caring support, as there were not enough staff. We were unable to review the tool on the day of the inspection and the provider agreed to send this to us afterwards. However this had not been received. This meant we are unable to be assured the tool was effective in identifying the level of staffing required. The provider has however informed us they have increased staffing hours following the inspection, and will be undertaking a review of people's dependency. We will check the effectiveness of this review at our next inspection.

Systems in place to monitor peoples risk assessments and plans were not effective. The provider had identified some people's risks assessments and plans required an update, and plans were in place to address this. This had not yet been fully completed at the time of the inspection. However, the system had not identified where risk assessments and plans were not being followed by staff or when new risks had emerged, whether prompt action had been taken. This meant the system for monitoring risk had not worked effectively and people were left at risk. The provider agreed to take immediate action to address these concerns.

Systems for monitoring safeguarding incidents were not effective. However, we could not be assured all incidents had been reported to the local authority safeguarding team for investigation. The provider told us they had some management changes which may have meant the reports were not submitted. This meant people may have been left at risk of harm. The provider told us they would take immediate action to investigate these concerns and make a referral to the local authority safeguarding body after the inspection.

We also found the systems to check staff competency were not effective in identifying where staff were not applying knowledge to their role. Some staff were unclear about safeguarding and how to apply the principles of the MCA. This meant people may have been at risk of harm and having their liberty restricted

unlawfully. The provider told us they would take action to check staff competency and give reminders using flashcards.

There were systems in place to check peoples care had been delivered safely. We found these were not consistently being completed by all nursing staff as required. The quality manager told us these had only recently been introduced and they would need to remind nurses of the importance of completing these documents. This meant the provider could not be assured people had received the care they needed.

We saw 'walk around' audits were conducted, these were carried out to check on the quality of the service people were receiving and looked at things like peoples dining experience and interaction with staff. However these had failed to identify the concerns we found with staff being unable to offer people the encouragement they needed at meal times or actively engage people in conversation. This meant the system was not always effective at identifying concerns.

These issues constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine audits were carried out, however they had not identified the issues we found with protocols and guidance for staff being missing when some people needed as required medicines. This meant staff may not have been aware of how and when to administer peoples medicines. The provider took immediate action to address this on the day of the inspection and said they would make improvements to the audits to ensure this was considered.

There was a system in place to monitor staff training. The provider told us they had identified gaps in staff knowledge and they had plans in place to address this. We saw there was a plan in place for staff to receive training the following month in how to support people with behaviours that challenged, and plans were in place to address gaps in other mandatory training completion.

People and their relatives told us there had been a number of changes to the management team. Some were unfamiliar with who was currently in charge, whilst others were aware. We were told the deputy was helpful and people had confidence in them, and some had met the new manager and said they felt they were approachable. One visitor said, "There have been managerial changes, I haven't met the new one properly yet, but would feel confident to talk to them if I needed to." Relatives also commented about meetings and opportunities to be involved in the service. Some described surveys, forms and meetings being used to enable feedback. However, not everyone was familiar with the opportunities available. Staff also had mixed views about leadership. Some told us there had been quite a lot of changes, but they felt able to approach the new manager and the deputy for support and told us things had started to improve over recent weeks. Others described a lack of managerial support at unit level. We saw records which showed staff had attended meetings and discussions had been held about what needed to change and how staff could assist. We also saw forms were available to seek feedback from people and relatives and meetings were scheduled for people and relatives to attend. This meant whilst some people, relatives and staff felt supported and engaged; improvements were needed to make this consistent.

The provider had an action plan in place to make improvements to the service. The quality manager sent a copy of the action plan for improving the service. They told us the actions came as a result of internal compliance inspections, inspections by the local authority and following this inspection and subsequent report, any further improvements noted would also be actioned. This demonstrated the organisation was using feedback to drive improvements.

The provider had submitted notifications to CQC in an appropriate and timely manner in line with the law. Services that provide health and social care to people are required to tell us about important events that happen in the service, we use this information to monitor the service and make sure the service is keeping people safe.

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 9 HSCA RA Regulations 2014 Person-centred care Peoples needs and preferences were not always understood and respected by staff. Staff were not ensuring peoples preferences were met.

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 Risks were not always assessed and planned for and peoples risk assessments and plans were not consistently followed by staff.

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 Systems in place were not always driving improvements and ensuring people received the care they needed to keep them safe.

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 insufficient staff available to meet peoples needs effectively. People were waiting for their care and support and staff were rushed which meant interactions were not always caring.