Tower Bridge Homes Care Limited

Tower Bridge Homes Care Limited - Sycamore

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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 15 February 2017 and was unannounced. During the inspection we found breaches of regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

Sycamore Court is a residential care home registered to provide care and accommodation for 39 older people. There were 34 people living in the service at the time of our inspection. The service was spread across two separate units. The ground floor unit supported people with mainly physical health needs and mobility difficulties, some of whom received their care in bed and many required the support of two care workers. The first floor accommodated people who were living with dementia.

The last inspection took place in February 2015 at which time the service was rated good in all areas. At that inspection a new manager had just been appointed and was going through the registration process. 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.

Since the previous inspection two further managers had been appointed. At the time of this inspection we were advised that the latest manager had withdrawn their application for registration and had given notice so the service was once again recruiting for a new registered manager.

We found that the high turnover of managers had resulted in a lack of stable and consistent leadership which was compounded by a lack of provider oversight of the service. This had impacted on the systems and processes necessary to monitor, assess and improve the quality and safety of the service.

Quality assurance checks and audits had been sporadic and were not as robust as they should be. The provider had not recognised the issues we identified during our inspection and had not always identified and taken action where people were placed at risk of harm or where their health and wellbeing was compromised.

There was a lack of mechanisms in place to include people and their relatives in the running of the service and request their feedback to drive improvements.

We looked at how medicines were managed by the service and found good practice guidelines were not consistently followed which posed a risk to people's safety.

There were systems in place to assess, manage and review risks to people however these were patchy and inconsistent and sometimes lacked detail. Recording of information around risk also required improvement

as it was not easy to find the most up to date guidance to keep people safe.

We looked at the staffing levels and found there were not enough staff to meet people's needs safely and in a way that protected their rights and maintained their dignity. We observed people having to wait to have their needs met. Oversight in communal and private areas to assist people was cursory and inconsistent and placed people at risk of harm.

During the inspection visit we walked around the home to assess the standards of cleanliness and found some areas of the premises were not free from odours and that disposal of waste products was not always appropriate. We have since had assurances from the provider that the necessary action has been taken to address these issues.

Safety checks were carried out but some areas of the home were potentially unsafe to people living with dementia. We highlighted the risks we had identified and the provider has since advised us that the environment has now been made safe for people.

People were supported to see, when needed, health care professionals. Care staff recognised changes to people's physical and emotional well-being and knew how to share this information and request input from external health and social care professionals. However, referrals were not always made or followed up in a timely way.

Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in activities of their choice and ability, particularly for people living with dementia.

Staff told us Sycamore Court was a good place to work as there was a strong sense of teamwork and said they felt supported within their role. However, staff felt the quality and scope of the training could be improved upon. From viewing training records we noted that staff training was in the main delivered via E-Learning and was not always up to date. After the inspection we were advised that steps have been taken to ensure all staff training was completed and the provider is exploring external training.

Applications had been made for Deprivation of Liberty Safeguards (DoLS) assessments for some people living at the service. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Discussions between us and the manager highlighted that a review of DoLS applications was required to ensure that people living in the home were not being deprived of their liberty unlawfully.

Staff supported people with decision making and involved them in choices about their care and support and people's consent for day to day care and treatment was sought by staff.

Where appropriate people were enabled and supported to be independent. Staff knew the care needs of the people they supported and people told us that for the most part staff were kind and caring.

The dining experience was positive and people were supported to have enough to eat and drink of their choosing.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were made welcome at the service.

Staff understood their responsibilities to protect people from abuse and were aware of the signs to look for

and reporting process if they suspected someone was at risk of harm.

Robust recruitment processes were in place to ensure staff were recruited safely.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely.

There were insufficient staff deployed to safely meet people's needs.

There were environmental hazards which posed a risk to people's safety.

Safe recruitment processes were in place.

Staff were aware of their safeguarding responsibilities and how to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of training and support for staff, particularly around moving and positioning of people.

A review of DoLS applications was required to ensure people were not being deprived of their liberty unlawfully.

People had enough to eat and drink and had access to healthcare services

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People's confidential information was not kept secure.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of activities and social interaction to stimulate and occupy people.

Improvements were required to ensure the environment was 'dementia friendly'.

Staff were familiar with people's preferences and treated people as individuals but people did not always receive person-centred care.

Complaints were dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A high turnover of managers and lack of provider oversight had resulted in system failings.

Systems and process to monitor and assess safety and quality were not robust.

Feedback from people who used the service was not consistently sought to drive improvements.

Tower Bridge Homes Care Limited - Sycamore

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.

The inspection took place on 15 February 2017. The inspection team was made up two inspectors, an inspection manager 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 safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke with the local authority responsible for commissioning a service for people from the provider.

As part of the inspection we spoke with the manager, the head team leader and six members of staff. We also spoke with sixteen people who used the service and five relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at six people's care plans and associated records, four staff recruitment files, staff training records and the staff supervision and competency checks. We reviewed a number of other documents relating to the management of the service including policies and processes, safeguarding, handling complaints, incidents and accidents and medicine management.

Inadequate

Is the service safe?

Our findings

Prior to the inspection we had received information of concern regarding the safety of the service which included concerns about staffing levels, medicine management and the cleanliness within the home. We also received feedback from the local authority highlighting many of the same issues as areas that needed to be improved upon.

Mixed views were expressed by people about whether they felt safe at the service. One person told us they did not always feel safe as; "People walk into my room and I can't stop them." However, they also said that when this happened they used their call bell and staff would come to their aid. Another person said, "They [staff] are very good; know what they're doing; I feel safe with them."

The provider used a dependency tool to measure people's care needs and work out how many staff were needed to provide sufficient support to people. Nevertheless, people told us that there were not enough staff. One person said, "Staff sometimes say, we've only got one on today so we're a bit busy; then they run in and out; I don't think they have enough staff." Another person said, "There's not enough staff, I see them rushing back and forth; they don't get a break or the chance to have a drink; that's not good for them." We saw that where people were alone in their rooms or unsupervised in communal areas staff did make the time to pop in and check on them but their visits were infrequent and cursory with no time to engage with people.

We observed that call bells rang frequently throughout the day, often switching from the regular alarm to the emergency alarm. Relatives told us that their family members had learned to use the emergency alarm rather than regular call bell as staff then responded quicker. We saw that the response time of staff varied with some people being attended to quite promptly whilst others waited for some time. Some people said that there were occasions when their call bells were answered quite quickly. One person said, "I fell once and I managed to get across to press it, they came quickly and helped me up; fortunately I was okay." However, four people told us that if they used their call bell staff would come and say they would be back but often would not come back due to being short-staffed.

Low staffing levels had impacted on people in a number of ways. People told us that they often waited a long time for help with personal care. One person said, "If I need to go to the toilet I have to shout; I can't go on my own; I find it a bit degrading as I don't want everyone to know." We reviewed two recent complaints from people which related to not responding to call bells and requests for assistance. This meant people had not received the care and support they needed to meet their personal care needs in a way that protected their dignity, health and wellbeing.

We spoke with relatives about staffing levels. One relative told us, "Staff always seem rushed off their feet here, call bells go off for ages; there seems to be less staff now than when [family member] first came here." People and relatives told us that since the service had removed the nursing stations it had become more difficult to find staff to help them and they had to go looking for them.

Staff also told us they were short-staffed. They said that many of the people they supported required the assistance of two members of staff which meant they could not meet people's needs in the way they would like. One staff member said, "We hear the bells go off and we want to help people but if we are already helping someone then we can't go to them." Another said, "If there is a medical emergency and one of us has to go off the floor for a few hours, there's only two of us left, it's dangerous." The impact on staff was that they felt stressed and under pressure. One staff member told us, "We're under so much pressure; it's very stressful; we don't get enough time to spend with people."

Our observations on the day indicated that there was a lack of staff to meet people's needs in a timely way. For example, we saw a person sat in the living room who was calling out for help. They told us they had been waiting a long time for a staff member to pass by so they could request help to go the toilet. There was no means available for the person to call for assistance other than to shout. Eventually we found a staff member and requested help for the person.

We spoke with the manager about our concerns who told us they had recently recruited six new care staff members. However, the new staff employed would replace agency staff so would not increase the actual number of care workers on each shift. After the inspection visit we raised our concerns with the regional manager who advised that a review of people's needs would be undertaken and that as an interim measure people in any communal area would be provided with a call bell so they could ring for assistance.

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely. Each person had a medicine administration record (MAR) which recorded the medicines that people were prescribed and when to administer them. These records included a front sheet which gave a picture of how people preferred to take medicines, their medical history, a list of their medicines and information on PRN (as needed) medicines. However, most of these sheets had not been completed for people. There were no PRN protocols in place to provide guidance to staff on when and how much PRN medicines to administer to people and why.

MAR sheets are used to record what medicines people are administered and at what time. We found gaps on people's MAR sheets so we could not be sure people had received their medicines as prescribed. The MAR records indicated there were instances when people had not received their medicines at all or had not received the correct dosage.

We looked at eight sets of records to establish whether safe stock control measures were in place and found that only one of the eight reconciled which showed that an accurate stock count of medicines was not maintained.

We found the index in the controlled drugs (CD's) register was not always kept up to date and did not demonstrate that any checks or controls were in place from senior managers. For example, we noticed an incorrect balance of a person's medicines had been carried forward and this error had not been identified or rectified.

No opening dates were written on CD medicines and there was a lack of guidance regarding how much to administer. We found one instance where there were two entries on the MAR for the same dosage suggesting that a person had been given their medicines twice. We also found some medicines stored in the CD cupboard that belonged to a person who was deceased which had not been removed and disposed of.

We spoke with the manager about our concerns. They told us that an audit had been completed to check the safety of medicines but that this had taken place on the ground floor unit not the first floor unit where the mistakes were found. The registered manager told us they would investigate the issues we had found and provide us with an immediate action plan to address the shortfalls to ensure people's safety. The regional manager later confirmed to use in writing that a new audit of the first floor medication had been completed to identify and address the areas of concern.

We also found environmental risks to people's safety on the first floor which was the dementia unit, for example, sharp pins that could easily be pulled out attaching pictures to the walls in communal areas. We saw that doors to stairways were not always closed securely and in one person's room a wardrobe was not attached to the wall. This meant that people living with dementia were not adequately protected from the risk of accidental injury.

Substances that could be hazardous to health if ingested were also left unsecured and within reach of people who might be confused and at risk of swallowing the contents, for example, cleaning materials stored in an unlocked kitchen cupboard. We also found that various prescribed creams and denture cleaning materials were left out on people's bedside cabinets or ensuites; there were no risk assessments related to these items being left unattended.

We also saw that food/fluid thickening powder had been left out open on a trolley in the dining room within reach of people who may be at risk of accidentally ingesting the contents. In 2015 a patient safety alert from NHS England had been released regarding the risk of accidental ingestion of fluid/food thickeners which had resulted in death from asphyxiation. Therefore care providers should consider how to keep people safe from this risk, including the safe storage of thickening agents.

We raised these concerns with the manager on the day of our inspection who gave assurances that the issues would be dealt with immediately to ensure people were kept safe. The regional manager later confirmed in writing that they had taken the necessary steps to secure the environment and make it safe.

There were systems in place to assess, manage and review risks to people, however these were patchy and inconsistent and sometimes lacked detail which meant that staff were not provided with sufficient guidance to keep people safe. For example, people had emergency evacuation plans to instruct staff to provide the support people would need to be evacuated from the building. However, these documents did not contain sufficient information detailing the exact nature of help and assistance people would require to evacuate them safely. The manager told us they were aware that improvements were required with regard to these documents and that it was their intention to address this.

The service completed a range of risk assessments which were reviewed monthly by the team leader as part of the care plan review. We saw that risk assessments were not consistently signed by people or their representative(s) so it was not clear whether people had been involved in decisions around risk.

Fluid charts were kept which recorded what people drank to minimise the risk of people becoming dehydrated but the records were not complete as most only recorded amounts up until 5pm. We found the information recorded was extremely repetitive with records showing amounts drunk that were an exact replica of the day before. However, we saw that people had access to hot and cold drinks throughout the day including after 5pm. Therefore the fluid charts did not represent an accurate picture of what people had actually drank throughout a twenty-four hour period which meant the information could not be used to accurately measure the risks of dehydration to people.

Charts for weighing people also lacked sufficient information to be able to accurately analyse and identify people at risk. People were weighed monthly but the chart did not indicate which day of the month they had actually been weighed on so we could not be sure if the weights recorded represented an accurate picture of people's weight gain or loss over a defined period of time.

Where risks were identified through the use of monitoring and recording we found that the service did not always respond appropriately to those risks. For example, where the monthly weight chart showed a person as losing a significant amount of weight over an eight month period, the frequency of monitoring their weight had not increased in response to the increased risk. There was also a delayed response in making a referral to the GP for dietician input and treatment.

The failings identified above represent a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The written risk assessment and management plans were not well utilised as they were kept in a folder with people's care records stored away in a room at the front of the building. This room was not easily accessible and staff told us that they did not routinely read these records. That said, the staff we spoke with demonstrated a good understanding of the risks to people and how they managed them. For example, one staff member said, "[person] is very anxious so there are risks to their emotional wellbeing; we make sure they have their familiar things around them that bring them comfort."

Staff told us that they communicated with each other on a daily basis both verbally and through the use of a daily hand-over book which they read when they came on shift. We looked at the book and saw that this was used to share up to date information about risk and changes to people's care needs, health and wellbeing.

Concerns had been raised with regard to the cleanliness of the service. We found that downstairs appeared clean and fresh throughout however on the first floor in some people's bedrooms there were unpleasant odours including a strong smell of urine. In one room, we found soiled continence pads inappropriately disposed of in a person's pedal bin.

We received mixed feedback from people regarding the cleanliness of the home. One relative told us, "The carpet often feels sticky to me, they could do with a deep clean I think." However another person told us, "They're excellent at cleaning, things are wiped down regularly; my bathroom is cleaned every day." We looked at the cleaning rota which showed some evidence of deep cleaning people's rooms but this was sporadic and had not fully addressed the issues.

We spoke with the manager about what we had found. They told us that they were recruiting for an additional member of domestic staff and that they had made improvements in terms of oversight of the cleaning rota to ensure all necessary cleaning tasks were completed. We looked at the rota and saw that there were gaps indicating that there were occasions when daily cleaning tasks had been missed. The manager explained that the gaps were due to staff absence and in these instances everyone would help out including management to ensure the home was kept clean but they would not always remember to sign the rota.

After the inspection visit the regional manager told us they had organised for carpets to be replaced in the problem areas we had identified.

Staff told us they had received training in how to safeguard people from abuse and they were aware of the signs that could alert them someone was being abused. They understood the reporting process and told us

they would tell the manager or go to the local authority if necessary. We saw that the manager recorded and dealt with safeguarding issues, including notifying us of concerns in a timely fashion.

Safe recruitment processes were in place for the employment of staff. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support.

Accidents and incidents were logged and the new manager had just started to complete a monthly analysis to help them identify any patterns and take any necessary actions to mitigate future risk. We saw that when people had fallen, management plans had been put in place such as the use of floor sensors to alert staff when the person was moving around so that they could monitor the person's safety.

The service employed a maintenance person who was responsible for the safety and maintenance of the premises and equipment both internally and externally. We saw that maintenance, fire drills and health and safety checks were regularly completed and recorded on both the premises and equipment including mobility aids such as wheelchairs and any necessary action taken to ensure the premises and equipment was maintained in good repair.

Requires Improvement

Is the service effective?

Our findings

People told us that staff did a good job. One person said, "Staff are fantastic; without exception I'm extremely happy here, it's excellent; staff don't get paid enough for all that they do for us." Another said, "They look after me well." Relatives also provided positive feedback. One relative told us, "I don't think we could ask for better care than here." Another said, "We've got confidence in them [staff], they have been kind and excellent at helping [person] settle in."

The service provided staff with training to equip them with the skills and knowledge to be effective in their role. The manager kept a training programme which detailed what training staff had received and when refresher training was due. We looked at this document and found that overall around 70% of training was up to date which meant that some staff training was overdue. We were advised that letters had been sent out to all staff whose training was overdue to remind them to get themselves booked onto training sessions.

The training provided was mostly delivered via E-learning and staff were not very positive about the quality of the training they received. One staff member told us, "It's rubbish, mainly E-learning." Another said, "Manual handling is on line, I had previous training in hoists so I know how to use them but I think we could do with more equipment training." Staff told us that first aid was also E-learning and that they felt practical hands-on training in this area would be more beneficial.

We observed several examples of poor practice with regard to moving and positioning people, for example, staff hooking people under the armpits to move them and placing their feet on the front of people's rollator frames whilst people used them to stand. Staff told us they had not had any observations of their practice to check their competence when moving and positioning people. We spoke with a person about their experience of being moved and positioned. They told us, "When my [relatives] move me they hurt me , they don't mean to but it shows you how important good training is; it doesn't happen with all the staff, only a few of them and I tell them 'You're hurting me'; not all of them listen."

One member of staff was a 'train the trainer' for manual handling people. We saw that they had just started to complete competency assessments on staff regarding moving and positioning but this was a new system which was not yet embedded and only three members of staff one of whom was the manager had been assessed.

The provider had not taken the necessary steps to assess and maintain staff competence. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes are called

the Deprivation of Liberty Safeguards (DoLS).

We found that Mental Capacity assessments and DoLS applications had not always been completed with regard to people living in the dementia unit who were unable to consent to the use of keypads to keep doors locked and restrict free movement. We spoke about this with the manager who agreed that a review of current DoLS applications was required to ensure that people were not being deprived of their liberty unlawfully.

The training matrix showed that sixty five percent of staff had received up to date training in the Mental Capacity Act and DoLS. Staff we spoke with were able to demonstrate their understanding of the principles of the Act and described how they supported people to make decisions for themselves. For example, by giving people choices and communicating in ways that helped people to understand information. One staff member told us, "I ask questions and offer choices, like for [person] I show them two plates; if I am concerned I would talk to the family or a senior."

We observed staff consistently offer choice to people and check their agreement before taking action. We saw one member of staff use a writing pad to talk to a person who had difficulty speaking so they could find out their wishes.

When new staff joined the service they had an induction which was based on the care certificate. The care certificate represents a set of minimum standards that social care and health workers should stick to in their daily working life. This was also delivered via E-learning, however staff were also given a written workbook to complete which was used as a learning tool and discussed during supervision sessions.

As part of the induction process new staff were provided with opportunities to shadow existing staff members and then work alongside more experienced staff to gain the necessary skills and experience. Staff told us that they found the shadowing process to be very valuable as this was when they learned about the people they would be supporting. They told us that they did not read people's care plans however they were introduced to everyone who used the service before they started working with them and that existing staff gave them a verbal hand-over to help them understand and get to know what each person needed. We found that staff had a good awareness of people's needs and were able to demonstrate that they understood how to provide the appropriate level of support to meet these needs.

Agency staff were also positive about the induction process. One agency staff member told us, "I was introduced to everyone and not just thrown in; they went through the policies and procedures; I worked with someone; not on my own to get to know people." A significant number of people required the help of two staff members which meant that staff often worked together. They told us that they found this very helpful for their learning and it provided them with support. One worker said, "We're a very hardworking team, a good team, we double up so we get peer support."

We asked staff whether they received regular supervision and received a mixture of responses. Some said they received supervision every six weeks whilst others said it was only every three months. One worker said that they used to receive supervision but this had lapsed when the last registered manager was in post. Nevertheless, staff told us that when they had supervision they found it beneficial and that they felt supported by management and the staff team. One staff member said, "I love it [supervision], constructive criticism helps me grow as a carer."

The service supported people to have enough to eat and drink. Drinks were readily available in communal areas with jugs of squash on tables and glasses of drink within people's reach. We saw that this was also the

case in people's rooms and people told us that their drinks were frequently topped up and that hot drinks were also regularly offered to them.

People told us they liked the food. One person said, "The food is very good." Another said, "The food here is beautiful, we can't complain about that at all." Meals were prepared by the cook and served to staff who all demonstrated an awareness of people's preferences. For example, one person was given their meal without beans or peas as the member of staff commented that they did not like either. People could choose where they ate their meals. Although some people took their meals in the dining room, others chose to have their lunch in their bedroom or the lounge and staff respected their choices.

During the lunchtime meal we observed that the atmosphere in the dining room was calm and relaxed. Staff laughed and joked with people and encouraged natural friendly conversation. A choice of drink was available and this was topped up when required. Condiments were on the table along with serviettes however whilst there was vinegar and brown sauce on a table in the corner, these were not offered to people. No menus were available on the table or in the dining room and people often did not know what they had ordered earlier. However, people were reminded of the choices available and we saw that people were able to change their choice and have an alternative.

Staff assisted people with eating and drinking where required and were quick to offer help to those that needed it, for example, cutting up food or offering support in a quiet and unobtrusive manner.

When people became unwell the service supported them to have access to the relevant health or social care professionals. There were records of liaison with health care professionals such as the GP, district nurse, physiotherapist and dietician. Staff used the daily hand over notes to communicate how people were feeling and identify if they required input from a health professional. For example, we looked at the daily handover notes and saw that where a staff member had noticed a person's skin was breaking down they had faxed a referral to the district nurse to come and review them. However, as highlighted previously in this report, the service did not always respond in a timely way to changes in people's health and wellbeing.

Requires Improvement

Is the service caring?

Our findings

The feedback we received from people and relatives was mostly positive. Comments included, "Staff are wonderful, all so polite." And, "I trust everybody they are marvellous." And, "They work hard; care about people and are full of love." One person said, "Staff are wonderful to me – I love them to bits; they're like my friends really, they really do care." However, two people had expressed concerns regarding rough handling by staff when being supported with transfers. One person told us, "They pull you this way and that; I tell them you're hurting me; they don't always understand how to move me and they don't listen when I tell them." The way that some people described their experience of being moved and positioned demonstrated a lack of caring.

We looked at six people's care records and found that consent forms and risk assessments were not always signed by people or their family members to evidence that they had been consulted and involved in their care planning. People told us that staff were too busy to ask for feedback on their opinions regarding their care. However, one relative told us that they were very grateful for the good communication levels between the service and themselves which had helped them to be more involved in their family member's care. The mixed feedback we received demonstrated a lack of consistency of people's involvement in planning their care and support.

Information and records about people was not always kept secure and stored confidentially. When we arrived we saw people's care records were stored on open shelves in an unlocked empty room with the door open. We spoke about this with the manager who advised that usually a member of staff would be in the office where the care records were kept but on the day of inspection this was not the case. We also saw records of people's food and fluid intake and bath records left out in the communal dining room which showed a lack of consideration for people's privacy.

Observations of staff interactions with people on the day of our inspection showed that people were treated with kindness and respect. Staff spoke to people politely and with kindness, called people by their preferred names and asked for permission before entering their rooms or providing any assistance. However, one person told us, "Staff treat us very well here, but sometimes we're treated like children, we're not children, I don't need to be told to say thank you."

Staff were aware of the importance of treating people with dignity and respect and were able to describe how they protected people's dignity when supporting them with their personal care, for example, through closing doors, shutting curtains and ensuring people were kept covered up. One staff member said, "Everyone has personal care differently, some have female carers only, I wait discreetly outside the bathroom for one person."

We saw that people were assisted to their bedroom or bathroom whenever they needed any care and support rather than being assisted in a communal area to ensure their dignity and privacy was maintained. However, despite staff familiarity with people and their awareness of the principles of promoting peoples dignity, low staffing levels meant that people's dignity was not always upheld, for example, people having to

wait extended periods of time to be assisted to the toilet.

Staff knew people well and showed a good awareness of their interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. A person told us, "They take me out for a fag last thing at night and first thing in the morning; we always have a good old natter together." A relative told us that their family member was interested in football and the staff knew this and engaged in friendly banter with them about football teams. One staff member had contacted the person's football team and arranged for them to have a signed letter from the Manager. The relative said, "This made [family member] feel like a person again."

People were supported to maintain relationships that were important to them. For example, one person's husband was able to join his wife every day for lunch. We saw that they had their own table together on their own and were able to eat together as they had always done.

We looked at six people's care records and found that the service had recorded an end of life care plan for people. One person had a preferred priority of care document which gives people the opportunity to express any preferences and choices around their end of life arrangements.

Requires Improvement

Is the service responsive?

Our findings

The service kept care records for people which were stored in folders in an office at the front of the building. This meant that information about people was not easily accessible to staff, particularly for those working on the first floor. We found the records confusing to read as it was difficult to find the most up to date information about people where this had been reviewed and amended. There were inconsistencies in terms of whether and how often people's care and support was reviewed and also with regard to the validity of the information as some of the documents and assessments were not dated.

Despite the disorganised presentation of the information we found care records did contain sufficient information about people's support needs and preferences and some background information about the person's life history to enable staff to provide person-centred care. Person-centred care is about understanding that everybody is unique and tailoring any care and support provided to each individual.

However, because staff had told us that they did not read people's care plans, we asked them how they ensured a person-centred approach. Staff told us because they had worked at the service for some time and knew people well they were able to provide person-centred care. Staff said that they talked to each other and shared information about people during their induction and at daily hand-overs to find out how to provide the care and support people needed and wanted. One staff member told us, "We do things how they like it; always give choice; always run things by people; if they don't want to get up they don't have to we never forget it's their home."

All of the staff we spoke with were able to demonstrate that they knew people well; were familiar with their preferences and knew how people wanted to receive their care and support. For example, one staff member told us, "[Person] likes things done in a certain way, wants to wear a certain cardigan, have a particular picture; likes for things to be perfect and likes to look perfect; they like their stockings pulled up to a certain point."

We found that staff worked hard to be attentive to people's needs and deliver care to them in the way they wanted. Some people did not have access to call bells in their rooms and we saw staff popping in and out of their rooms throughout the day checking whether people were okay and needed any assistance. However, because staff were so busy carrying out support tasks they were unable to spend dedicated quality time with people. This meant that workers were not always able to provide care in a person-centred way.

We were told that the service had recently introduced keyworkers so that people would have a particular staff member who would take the lead on providing their care and support and get to know them really well and be the point of contact for the person and their family members. However, because of the lack of staff, staff told us they had been assigned as keyworker for too many people for the system to be truly effective. One staff member said, "I am keyworker for ten people so they don't get the attention they need."

Whilst staff had a good understanding of how to support people with dementia we found that the home environment was not particularly 'dementia friendly'.There was a lack of stimuli around the home such as

clothing, rummage boxes, pictures and objects for reminiscence to engage people's interest and stimulate conversation between staff and people.

We found that the service provided limited opportunities for social interaction and stimulation. On the day of our inspection we did not observe any activities or attempts by staff to arrange or encourage participation in activities. Staff we spoke with told us they did not have time to arrange activities. One staff member told us, "I try to put a DVD on if I can and there are occasional visiting entertainers but we do not have time."

People said that the service had arranged a Christmas pantomime which they had enjoyed. One person told us, "We'd like a bit more going on like that, we just sit and go to sleep often." Another person remarked that they spent most of their time in their bedroom. They said, "I go to bingo about once a fortnight because they know I like that; they come and get me and take me to the lounge; we have entertainers less often than that but they're good."

On the notice board in the main corridor there were details of very few upcoming events. One person told us, "There's not enough stimulation here, we need an entertainments officer; some people are very bored I can see it."

We asked people if they had enough to do. One person said, "The TV is always on but it's very quiet so we can't hear it; they never ask us what we want to watch it's just on; people don't really watch it." Another person told us that they never went into the lounge area because; "They're always asleep, there's no point; it would be different if there was someone to talk to or something going on."

We carried out observations in communal lounge and dining areas and saw there was minimal interaction from staff with people until they started getting people ready for lunch. The provision of meaningful activity and social interaction was not being provided for people as an important aspect of meeting their social care needs and to promote their independence, health and wellbeing.

We spoke with the manager regarding the lack of activities. They advised us that the service had previously employed an activities co-ordinator but they had left. However, two new members of staff had been recently recruited to job share the role of activities co-ordinator and they would be starting as soon as the recruitment process had been completed.

We recommend that the service follow good practice guidelines around supporting older people, including those living with dementia, with sufficient opportunities for stimulation and social interaction.

The service had systems and processes in place to respond to complaints. We reviewed the complaints log and found that the manager had investigated and responded appropriately to people or relatives' concerns within the agreed timescales. For example, where a person had complained about how they were spoken to by night staff the manager arranged a supervision with the staff member and completed an observation of the night shift.

Due to the frequent turnover of managers, some people and relatives told us they did not know who to complain to as they were not sure who the manager was. However, the deputy manager had worked at the service for a long time and provided a stable point of contact for people. One person said, "If I had a complaint I'd speak to [deputy] I trust them with my life."

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who had started the process of registration but this had been withdrawn as they had given notice to leave the service. The regional manager confirmed that they were actively recruiting for a new registered manager and in the interim the senior team leader who was a long term member of staff would act up as manager.

Our records showed that there had been a high turnover of managers at the service which had led to confusion amongst people and relatives about who was in charge. Comments from people and relatives included; "I don't know the managers name, I don't see them, they are rarely out of their office." And, "I'm not sure who the manager is, I don't think they have been to see me." And, "I don't' know what this new manager is like or whether they would listen to me, I've only met them once since they have been here." Only one person we spoke with was able to name both the manager and senior team leader. They told us that they felt able to speak to them about any issues that arose.

In spite of the frequent changes, staff told us that they felt supported by the current management and valued the senior team leader who was a consistent presence and always available to provide them with help and guidance. Comments from staff included, "The manager made me feel welcomed." And, "The manager has just started, I'm not sure what their second name is but they try to help." And, "Managers do listen, I say what I think and they try their best to help; they make me feel like I'm doing a good job." Staff also spoke positively about the new regional manager who had recently been appointed and said they now felt more supported and listened to. One staff member said, "The new regional manager is good, they listen to us, we definitely feel more supported than we did before."

We found that the instability of management and a lack of oversight of the service by the provider had impacted on the day to day running of the service. Systems and processes to support staff had been affected such as appraisals and observations of staff practice. This meant that staff learning and development needs had not been identified, for example, in moving and handling techniques and practice. Other important aspects such as staff and residents meetings had also lapsed. We saw that when the previous manager had been in post there were only two staff meetings held in 2016 which were eleven months apart. When the new manager joined they had taken steps to address this and had scheduled a staff meeting for January 2017 but this had then been cancelled.

Quality assurance systems and processes to monitor the safety and effectiveness of the service and drive improvements had also been affected due to a lack of consistent oversight of the service. Records showed that some quality assurance mechanisms had stopped entirely under the previous registered manager, for example, the monthly infection control audit which had not been completed since May 2016.

The new manager had begun to address the shortfalls and had completed recent audits in January and February 2017 to monitor aspects such as care plans, infection control and accidents and incidents. However, the new systems were not yet embedded and we found that they were not robust as they had not identified many of the concerns we found during inspection. For example, a medicine audit had been

completed in January 2017 but this had not picked up the issues we had found.

Where audits had identified issues of concerns, the necessary action had not always been taken to make improvements. For example, an infection control audit had been completed which had identified that some people's carpets were 'smelly' but on the day of inspection we found that this was still an issue.

The provider had not taken the necessary steps to obtain feedback from people about the quality of the service they received or to involve them in the day to day running of the home through the use of residents meetings or satisfaction surveys. None of the people we spoke with knew anything about residents meetings or could recall being given a satisfaction survey to complete. One person said, "I don't go to them because I don't know about them. Another person said, "I don't think we have meetings, not that I know about; I've not been asked my views about anything."

Records showed that a relatives meeting had been held at the beginning of December 2016. At this meeting relatives expressed concerns about consistency of management, and the quality of sheets and towels. We saw that the action noted by the service was to order new bed linen. However on the day of inspection we found that the standard of bedding upstairs was not consistent, for example, in two bedrooms we found duvets that were thin and lumpy. This showed that the service had not followed through on identified actions to improve the quality of the service.

We spoke with the manager about our concerns and they told us that they planned to have residents meetings every three months and showed us that a schedule was now in place to make sure this happened.

This service was previously rated as good in 2015 since which time we have now found significant failings as the provider has failed to operate effective systems and processes to assess, monitor and improve the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst staff told us that they felt stressed and under pressure there was nevertheless a positive, open, honest and supportive culture within the service where staff shared the same vision and values. These were expressed by one staff member as; "Trying to provide the best care we can and give all the support people need." Another worker told us, "I always have time for people, no matter what I am doing, even when we are short." All of the staff we talked to spoke highly of the teamwork and support they received from their colleagues. One worker said, "We all pitch in and help each other out." We saw these expressed sentiments in practice on the day of inspection with staff working very hard to give people what they needed and make time for them with the resources they had available.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess, record, manage and review risks to people. The provider had not ensured that the premises were safe and used in a safe way. The provider had failed to ensure the proper and safe management of medicines. .

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems and processes to assess, monitor and improve the safety and quality of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of staff were deployed to meet people's care needs safely. The provider had not taken the necessary steps to assess and maintain staff skills, knowledge and competence.