CareQuality Commission

Sentry Care Limited

Shire House Care Home

Inspection report

Sidmouth Road
Lyme Regis
Dorset
DT7 3ES

Tel: 01297442483
Website: www.sentrycare.co.uk

Date of inspection visit:
10 May 2016
11 May 2016
12 May 2016

Date of publication:
27 June 2016

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

The inspection took place on the 10, 11 and 12 May 2016 and was unannounced. We previously inspected the service on 10 January 2014 and found all requirements were met.

Shire House Care Home provides residential care without nursing for up to 22 older persons. There were 21 people living at the service when we visited.

A registered manager was employed to manage the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was available on the first day of the inspection, but was due to do night duty on the second day so was not available on this or the third day. The registered provider supported the inspection on the second and third day.

Prior to the inspection we received information of concern about staffing levels. We found there were not enough staff to look after people safely. People were at risk of not having their needs met, falling and of having their dignity compromised. Staff were moving people unsafely as there was not always another staff member who could work with them to support moving or caring for people. This was even when care records clearly stated two staff had to do this. The provider and registered manager had not acted when staff had raised a concern about this. We requested the provider took immediate action to ensure there were enough staff to meet people's needs safely. The provider responded to this request by ensuring four care staff were available between 8am and 8pm. They also agreed to review how they calculated what number of staff were required according to people's needs. We also had concerns about the emotional and physical safety of staff so we spoke with the environmental officer to advise them of our concerns in respect of staff health and safety. The environmental health officer visited on the second day of the inspection and communicated with the provider.

People gave us mixed accounts of whether they felt staff were caring. People explained staff were really busy and they did not want to be a nuisance. People said both positive and negative things about the staff. Staff told us eight people living with dementia were deliberately targeted so they were ready for bed by the time they night staff came on duty at 8pm. This was because these people were unable to communicate they did not want to go to bed. The provider agreed to review this practice.

People had detailed care plans in place which were reviewed with them and their representative. Staff said they read and understood the care plans but were unable to always follow them as they were too busy. Staff told us they had to make decisions about limiting people's choices and preferences due to the lack of staff. Staff wanted this to change and felt people living at the service deserved better.

The provider had systems in place to judge the quality of the service but as they believed there were enough

staff, the issues identified on inspection were not reviewed as part of that auditing process. Staff felt the culture of the service was task focused. They felt they were not always listened to when suggesting changes.

People were at risk due to staff delivering care whilst also making people's tea time meal. Staff were wearing the same uniforms and inadequate cover to prevent cross contamination. Staff told us they washed their hands before returning to food preparation. The person completing the medicine round was also called away to help with care. People's medicines were administered safely but interrupting the round can increase the possibility of mistakes taking place. We have asked the provider to review the latest guidance in respect of this and also review how they rotate and manage the stock of medicines.

People had individual risk assessments in place to support staff to look after people. There had been a high number of falls in 2015 and 2016 to date. The falls had not been reviewed to ensure this risk was then mitigated. Other areas such as the time of the fall, staffing and call bell response times had not been reviewed to identify why people were having falls at this level.

Staff had some knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's ability to consent to their own care was being assessed but the assessments were not always specific or detailed how staff were acting in people's best interest. We observed some people did not have their right to consent to any care respected. We have been advised the registered manager and provider planned to review the issue of consent with staff to improve practice.
People had their need for food and drink met in most cases. Where there were concerns people's needs were reviewed. However, we found one significant concern where the understanding of assessments of how people's needs for their food to be prepared to prevent choking was misunderstood by the registered manager. Also, people in the lounge did not have drinks available to access when they wanted to.
Activities were provided to keep people cognitively and physically stimulated. People's religious needs were met and they could go out into the community. There was an activity co-ordinator employed most days. They were sometimes called away to support care needs which could reduce the amount of activities available to people.
Staff underwent a level of training to ensure they could carry out their role effectively. Staff understood how to identify abuse, report this and ensure action was taken to keep people safe. Staff were recruited safely.

People's complaints were reviewed and they received feedback to ensure they were happy with the outcome. The provider had systems in place to ensure the equipment and premises were safe.

We found breaches of the regulations. You can read what action we have told the provider to take at the back of the full report.

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 always safe. There were not enough staff to meet people's needs safely.

People were at risk of food poisoning due to the poor cleanliness in the kitchen and food preparation being completed by staff who were also carrying out personal care. We have advised environmental health of our concerns.

People's medicines were administered safely. We have recommended the provider and registered manager review the latest guidance in respect of some aspects of the management of medicines.

People had risk assessments in place which were updated as their health and welfare needs changed. However, there was a high falls rate which was not reviewed to see if lessons could be learnt to mitigate risks to all people living at the service.

Staff demonstrated they understood how to identify and keep people safe from harm. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People had their nutritional and need for enough to drink met, but we identified that for some individuals this needed improvement.

People saw their GP and health professionals but we identified one person who was at risk as they had had diarrhoea for four days and advice had not been sought.

People were assessed to see if they could consent to their care. These were not always identifying specific issue decisions in line with the Mental Capacity Act 2005 or identified when staff were making decisions in people's best interest.

Staff did not always seek consent before offering care.

Is the service caring?

Requires Improvement

The service was not always caring. We received a mixed view from people as to whether staff were caring. We observed both good interactions from staff to people and others which needed to improve.

Staffing issues were impacting on staff delivering care with respect and compassion.

People's end of life was planned with them. Staffing levels were felt to impact on this time.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some people's care was not personalised. Staffing issues were affecting the staff's ability to be responsive to people's care.

Activities were provided to keep people active but these were dependent on staffing levels. People had their faith needs met.

People's complaints were reviewed and the outcome fed back to people to ensure they were happy

Is the service well-led?

Requires Improvement

The service was not always well-led. Systems were not in place to ensure there were enough staff.

Not all staff felt they were listened to when changes were suggested.

Systems were in place to ensure equipment was checked and the premises maintained.

Care Quality Commission

Shire House Care Home

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 the 10, 11 and 12 May 2016 and was unannounced.

The inspection team was made up of one inspector from the adult social care directorate, a specialist social worker with knowledge of older people's care 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.

Prior to the inspection we reviewed the information we had received from or about the service. This included the notifications we had been sent, the previous inspection report and the Provider Information Return (PIR). Notifications are specific events registered people have to tell us about. PIRs are a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

While at the service we spoke with 15 people and three relatives. We reviewed the care records of four people in detail and spoke with them where this was possible. We did this so we could seek their view of their care.

We reviewed three staff personnel records and the training records for all staff. We spoke with six staff which included staff who delivered care, the activity co-ordinator and the cook. We observed how staff interacted with people living at the service. The registered manager was available on the first day of the inspection, but was not available during the rest of the inspection. The registered provider supported the inspection on the second and third day.

We also reviewed the records held by the registered manager and provider to measure the quality of the service. This included a number of audits and maintenance records.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received information of concern that there were not enough staff to provide safe care to people. We reviewed the staffing as part of the inspection process and we found there were not enough staff to meet people's needs safely.

On the first day there were three care staff from 8am-8pm to care for 21 people. Two staff were on duty overnight from 8pm-8am. The home was placed over three floors. People on all three floors needed one or two staff to meet all or part of their needs. As well as care duties, staff had other tasks given to them such as laundry responsibilities and preparing the evening tea time meal. Staff overnight had cleaning and other duties to complete. One staff member said, "I am not really happy [with the staff numbers]; sometimes there are only two carers. We can't see to people's needs then. Other times there are three and it is not enough. There are many tasks and duties to do on top of the care people need."

People told us staff were very busy and they limited using their call bell because they did not want to be a nuisance. People also told us they felt waiting up to 20 minutes to have their call bell answered was acceptable; even if this put them at risk of wetting or soiling themselves. Also, people said they would try to get to the toilet by themselves even if this put them at risk of falling. We observed staff were busy the entire time. People in the lounge rarely saw a member of staff in the morning unless it was the drinks round. In the afternoon the activity co-ordinator was available, but they were requested to meet care needs and support other staff, so were taken away from people. We overheard a conversation between people in the lounge. One person, who required staff support to go to the toilet, wanted to get up and move by themselves. People in the lounge advised the person this was not safe. A person was then heard to state, "You will have to wait for a member of staff to come along when they can."

Staff told us there were not enough staff; they would answer a call bell if they could and risk moving a person by hoist, rota stand or to stand and use their walking frame or wheelchair alone. This was despite them knowing the person required two staff to carry out the task to keep the person and themselves safe. In respect of one person, staff told us they knew the person wanted to go to the toilet if they rang for assistance, but it would take a further 10 to 20 minutes for another staff member to come and help. They would go ahead and support them anyway. We found another person had experienced two falls in their en-suite toilet when one staff member supported them to have personal care or go to the toilet. This person's manual handling and falls risk assessment stated they required two staff to complete both of these tasks. One staff member said, "We have no choice; we have no one to help as staff are busy doing other things." When staff had shared their concern about this person's safety with the provider and registered manager action had not been taken.

We asked the registered manager and provider about the staffing numbers and how they calculated staffing levels. The provider stated they were meeting the guidelines laid down by NICE (The National Institute for Health and Care Excellence) which stated the correct number of staff was one staff member to eight people. We were unable to find this information on NICE's website. When asked, the provider told us he had heard this fact when listening to the radio. We asked how the provider was ensuring staffing levels were reviewed

continuously to ensure they had the right number and skill mix to meet people's changing needs and circumstances. We asked if they were using other data to gauge they had enough staff such as people's dependency levels, the falls rate and how long it took staff to answer call bells as a measure to see if people's needs were being met by the current staffing ratio. The provider advised they were not using any other system to ensure they had enough staff.

Not having sufficient numbers of staff to meet people's needs safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested the provider take immediate action to address the staffing of the service as we felt people were at immediate risk. We advised the local authority safeguarding adults' team of our concerns. As we were concerned also about the emotional and physical safety of staff, we spoke with the environmental officer to advise them of our concerns in respect of staff health and safety. The environmental health officer visited on the second day of the inspection and communicated with the provider.

The provider responded to the request of staffing by ensuring four care staff were available until 8pm on the second and third day of the inspection; the same number was promised for the 13 May 2016. They also interviewed new staff and requested their employment checks. Up until they were able to ensure the new staff were suitable, the provider made a verbal commitment to ensure there was a minimum of four care staff between the hours of 8am-8pm. They also committed to putting a system in place to measure whether they had enough staff to meet people's current needs.

People living at the service had experienced a high number of falls and accidents in 2015 and 2016 to date. In 2016 to date there had been 31 falls experienced by 12 people. The majority of falls were in the afternoon when we identified there were three staff completing care whilst also preparing food, working in the laundry or administering medicines. All except one fall was in the person's own room. Although the provider collated this information together and reviewed the person; there was no analysis of the overall risk being posed to people. Systems were not in place to see what learning could be taken from the high number of falls people were experiencing.

Not assessing the overall risk to people in respect of their falls is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place which were updated as their health and welfare needs changed. These risk assessments covered the risk of falling while being manual handled, of developing pressure sores and of malnutrition. There were no individual risk assessments people's other needs. For example, there was no risk assessment in place for people who were diabetic or were taking a blood thinning drug such as Warfarin. When we discussed this with the registered manger they looked for ways to risk assess these needs. This meant people's specific risks would then be monitored.

People were not protected by good infection control practices in all areas. People were at risk of food poisoning. We found the kitchen to be unclean with dirt on the floor under the units and sticky substances on areas such as cupboard doors. Staff who delivered care prepared people's evening tea. We found they wore the same uniform in which they delivered care and were not covering this with adequate protection. For example, they wore fabric aprons which only covered their lap. The same staff had to deliver personal care and deal with laundry and then return to food preparation. One member of staff said when they last prepared food, "The other two were answering the bells. I also had to answer the bells; someone had urinated in the bathroom and I had to take off my kitchen robe and clean it up." We found the provider had not risk assessed staff preparing food whilst carrying out other tasks which may lead to contamination of

food.

Staff who were administering medicines were called away from their role to carry out care. On the first day of the inspection, this was to care for a person with diarrhoea who had not been assessed as to whether they were infectious. Staff told us they made the decision the risk was less to the staff member administering medicines than the staff member making people's tea at that time. However, there was still a risk of cross-contamination.

Not ensuring infection control in respect of food preparation was in place is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Food preparation surfaces were cleaned and the floor mopped after each serving of breakfast, lunch and tea. No other cleaning of other surfaces or difficult to reach floor areas was taking place. We contacted the environmental health department to share our concerns that people were being placed at risk due to issues with food preparation and cross contamination from staff carrying out mixed roles. The environmental health officer visited on the second day of the inspection and communicated with the provider.

Staff practised safe infection control when delivering personal care and described how they always used new aprons and gloves for each person.

People's medicines were administered safely. People's medicines were ordered in advance and as needed to ensure their current medicine was always available. Everyone told us their medicines were administered on time and as they would like. One person said, "I do get my medication on time each day, and I can get the Dr if it's needed, I use the same GP that I had before I came to the home." Medicines were given to people as prescribed. Medicine storage rooms and fridge temperatures were monitored daily and a record kept to ensure the temperature was in the correct range. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Medicines Administration Records (MAR) were all in place and had been correctly completed. Clear direction was given to staff on the precise area prescribed creams should be placed and how often. Staff kept a clear record to show creams were administered as prescribed.

The management of medicines was not always safe. We discussed with the provider the concern staff who administered medicines were not protected and were called away to complete care tasks which increased the likelihood that errors could occur. We also discussed the stock of medicines as this was not being well managed. Stock of medicines was high for several people. For example, one person had 438 of a strong painkiller of which they took one a day. Another had 468 paracetamol available for which they were prescribed up to eight a day. Stock levels of medicines were not monitored or carried forward on the MARs and staff were not using the medicines with the longest date since dispensary first. New medicines were ordered each month regardless of whether there was stock available. It was not possible to see whether medicines levels were accurate. Some medicines held for people had stopped some time ago but were still being held as part of that person's stock of medicines. The provider started to review the concerns during the inspection and gave a verbal agreement to ensure staff administering medicine would be able to complete the medicine round without interruption.

We recommend the provider and registered manager review the latest guidance in respect of ensuring staff administering medicines are not interrupted, rotating medicine stock and managing the stock of medicines.

Staff were knowledgeable about safeguarding people from harm and abuse. They received regular training in safeguarding vulnerable adults. Staff were knowledgeable about what constituted abuse and would pass

on any concerns. One person said, "I do feel safe," and when asked if there was anything particular that made them feel safe they replied that the staff were very pleasant people adding, "I press the button and then they are there for me." Another person said they felt happy and safe at the service adding, "I can talk to any of them [the staff] if I have a concern and it's taken up straight away."

People were supported by staff who were recruited safely. Robust recruitment practices were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. People said new staff were introduced to them and were supported by a more experienced member of staff.

Requires Improvement

Is the service effective?

Our findings

People had their nutritional needs met. People were asked in advance what they would like to eat. People were complimentary about the food and said the portions were large enough. One person said, "The food is excellent and I enjoy the choices we get. The puddings are good too" and another said, "I enjoy the food here. It is mostly the sort of thing that I would choose". People's likes and dislike were sought from them or from getting to know people. People's special dietary needs were catered for. People were supported by staff to eat regularly. What people had eaten was carefully recorded and monitored, where required. Any concerns were acted on. For example, people who were losing weight or were observed by staff to struggle to eat certain foods were referred for assessments.

One person, however was not being supported to follow guidelines put in place to help ensure they were safe when eating. For example, on the 8 May 2016 it was recorded in the daily records they were served toast for dinner. This was despite a SALT (Speech and Language Service Team) assessment stating their food had was to be as a "Soft diet; hard foods need to be pureed" to prevent them from choking. The assessment also advised the person should be sat out in a chair to eat; we observed the person being propped up in bed to eat. We discussed this with the registered manager who advised they had been discharged from the SALT service. She added that she believed therefore that the need had been met. We explained the person was likely to have been discharged because a care plan was in place with additional advice to re-refer if the person's needs changed. We were told by the registered manager the person wanted and enjoyed the biscuits and family had requested they were not denied. We were also told the person had capacity to make their own decision. None of this had been recorded and advice had not been sought from the SALT service to see how they could help the person enjoy their biscuit safely. The registered manager stated they would review this and seek any advice needed while continuing to respect this person had the right to make choices about their own care.

People had their hydration needs met by being offered drinks regularly; though people said these were often late. People had jugs of water available in their rooms which they confirmed were changed daily. In the lounge, people did not have fluid available which they could access themselves. People were offered drinks outside drinks rounds but this depended on staff being available. People's intake was monitored if there was a concern about them not drinking enough to keep them hydrated.

People had access to their GP and other health professionals. People saw the chiropodist and dentist and an optician visited people often. People also had regular health reviews related to their specific conditions. They also had regular medicine reviews with their GP. One person told us how they had developed a skin irritation and the staff had asked the GP to take a look. Creams had been prescribed and the staff had used this on them and their skin was now clear. However, we were advised one person had had diarrhoea for four days and the staff had been managing this by limiting their food intake. The person told us they were hungry and would like to eat the lunch available. We asked if staff had sought advice from the GP or district nurse (who attended the service daily to see other people) as this person may have been infectious or had another unknown medical condition. We were advised staff had not sought advice, but a GP was phoned and the GP reviewed the person the same day.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

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. Records showed people's capacity was reviewed as required by the registered manager. Staff demonstrated they had some understanding of how to apply the mental capacity act to their work having had training in the area. However, specific issues that may affect people's ability to consent were not always assessed to ensure people could consent or may have needed support to do so. People's best interests were not always clearly recorded. This meant staff sometimes had limited information available to ensure they knew when they were acting in people's best interest.

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 is called the Deprivation of Liberty Safeguards (DoLS). We were advised by the registered manager they had applied for DoLS; some of these were awaiting authorisation by the local authority designated office. They added they would also seek advice about the need for a DoLS authorisation if they were unsure. Staff as a whole knew about DoLS and one member of staff said, "I am aware of when to intervene [in relation to DoLS]; the front door is locked, no one goes out unaccompanied, we've got a few people on DoLS."
On the first day, we observed staff ask people's consent to offer care and we also saw times when this was not in place. For example, we observed a person having their temperature taken in the lounge without talking to the person first and seeking their consent.

We recommend the registered provider and manager review the latest guidance in respect of seeking consent and the MCA and DoLS with staff to ensure knowledge and practice is improved.

Staff received training to carry out their role effectively. Staff were trained in a range of areas to support their understanding of people's needs. Staff were trained in the subjects the provider identified as key to working within the service. For example, all staff received training which kept their skills up to date in safeguarding vulnerable adults, manual handling, first aid and looking after people with dementia. Staff received annual appraisals and some time on their own with the registered manager or provider to reflect on their practice, training needs and personal development. One person told us they felt the staff were well trained to use the hoist with them adding, "I feel safe when they use the hoist; they make sure you are strapped in properly" We observed staff speak to them in reassuring tones.

Staff said they received training, three said they were currently taking a diploma in care, and said they felt sufficiently skilled to carry out their roles. One staff member said they had worked at Shire House for 18 months and, "Had quite a lot of training; if I want additional training then the [registered] manager or the owner will usually arrange it".

New staff currently underwent the service's induction and shadowed experienced staff before taking up duties on their own. Staff said they enjoyed being involved in inducting new staff and one said the induction they received had been thorough and effective and she had felt supported throughout. The provider was not aware of the Care Certificate which is a national induction for all staff new to care. This was introduced in April 2015 to ensure all staff new to care are trained to the same standard. The provider stated they would seek to inform themselves about the Care Certificate and introduce it as soon as possible.

Requires Improvement

Is the service caring?

Our findings

We observed the home to be calm with people able to personalise their own rooms. We received contrasting views from people living at the service as to whether they felt the staff were caring and looked after them with respect and compassion. If people were negative about staff they added they understood staff were very busy, but staff tried their best to do what was needed for them.

One person told us, "At least half the staff are really good, while the others are not as good as they could be." Another person told us, they felt instructions about how their care is provided were not respected by all the staff. They added, "They call me impatient" and, "I don't feel they listen to me. Isn't that the case of all old people? Most of the staff are OK; it's just one or two that are difficult."

On the first day we observed staff could be caring but were task focused which made some of their communications and interactions brusque and appear less caring. Staff told us they were concerned they could not meet people's full needs and wanted this to change and felt people living at the service deserved better. A member of staff said that rather than get one person dressed when transferred between bed to chair, "It's quicker and easier to hoist them and leave them with just a blanket to cover their lower half". Another member of staff described how another person was "not asked or respected but presented with everything" due to staffing levels. A third member of staff said, "We try our best to care properly for people; even if we don't have a break. We carry on working."

Staff were especially concerned they could not meet people's social and emotional needs as they needed to move onto the next person or complete set tasks. One staff member said staffing was, "Not adequate and it does impact on care" and, "The culture of the home is very task driven. Staff have a list of tasks to be completed, but there is no time for individual personal care – personal care is seen as a task to be completed." On the third day as there was more staff, we observed a change in staff and how they related to people. We observed staff in the lounge sitting and speaking and sharing time with people.

People's end of life was planned with them; clear details were included in their care records about how they wanted their end of life to look like. Staff underwent training in end of life. Staff raised with us however, that they were pressured and felt they were not given the time to sit with people, who had no one else, such as family, at their end of life. Staff said they hoped this would change with the increased staffing.

One person said, "The staff treat us very well. My family come and visit - they can come and visit at any time it's no problem" and another said, "The staff are very good; one hundred per cent. They are always well mannered. Yes it's pretty good here". A third person told us, "The staff are very nice; they come and ask you how you are; they care about the old. They care about you."

Requires Improvement

Is the service responsive?

Our findings

Two people told us their life was being limited by staff availability. They told us staff were ignoring their request to socialise with others at lunchtime. One person said, "I have felt very left out the last two weeks" since they required their leg to be bandaged and their ability to stand and walk had been affected. Both people's care records detailed two staff were required to hoist and move them. We asked staff why this request to eat in the dining room was not being fulfilled. Staff told us they did not have time or enough staff to support them in this way and ignored the request to eat in the dining room as a balance of meeting everyone's needs. Staff told us they continually had to limit what they could do for or with people in line with the demands on them at that time. We checked on the third day of the inspection and were told both people had lunch in the dining room and one staff member commented "Everyone found this a positive time".

Another person told us, "Things don't get done if they're busy." They added their needs had become greater and needed more staff time. They felt staff did not understand this. They felt staff did not have the time to discuss this change with them at their speed. They stated, "Staff just keep telling me to be independent." We spoke with the registered person about this person's needs and they agreed to review them.

Staff told us they were under pressure to support a set number of people to get ready for bed between 7pm and 8pm to ensure there were less people for the night staff to support. Staff meeting minutes from the 7 October 2015 emphasised the importance of staff achieving this. Eight people living with dementia were identified by staff to us. They had to be ready for bed by 8pm regardless of what the person's choice would be. We were told these people were deliberately chosen due to their lack of cognitive ability. One staff member said it was, "Because they can't get their feelings across." They added they tried to ask if these people were ready for bed but, "We are pressured to get so many ready for bed by 8pm." If this is not achieved, staff told us they were asked why. We discussed this issue with the provider, who advised he felt people living with dementia were, "More tired than other people", and were often asleep in their chair. We asked how they knew the bed times chosen were in line with how the person would want their care delivered if they were able to say. The provider agreed to review this practice to ensure people's personal choices were respected. .

Not providing care with a view to achieving people's preferences and ensuring their needs are met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed before coming to live at the service to ensure the staff would be able to meet their needs. People could visit the service if they chose to and assess whether they wanted to live there. People's initial needs were collated into an initial care plan so staff could meet their needs. We saw one person had recently stayed for a short stay and returned to their own home. When they returned to the service for a second time, staff completed a new initial assessment of their needs to check what had changed and to ensure the service could still me their needs.

People had care records which were personalised and were reviewed with them or their representative every

month to ensure they were an accurate account of their current needs. Staff were aware of the care plans and people's needs. All staff had a good level of knowledge about people they were looking after and their individual needs. They knew everyone's names and room numbers and appeared familiar with people's day to day routines. One member of staff gave an example of understanding delivering a person's care plan for skin conditions remarking, "Any injury or mark is recorded, cream charts are signed and we ensure pressure sores are reported if open; any concerns we contact the district nurse" and indicated a good relationship with the district nurse team. However, staff said they felt limited in meeting people's needs due to there not being enough staff to meet those needs.

People were provided with activities to keep them physically and cognitively active. One person said, "We sit and do exercises sometimes and I am very happy here - they are nice people" and another, "Sometimes people come in and sing to us or they bring animals to us as well. They bring an armadillo in sometimes which rolls into a ball to protect themselves." People could maintain their links with the community. One person told us, "I get to go out. Today I went to singing. For me the joy of life is singing". There was an activity co-ordinator employed to support people to remain active. Although they were also asked to support care, activities took place on a one to one basis or in small groups. People had a quiz, large piece jigsaws and other activities provided while we were there. There was a minibus which could be used for organised and informal trips. People could go out in small groups or on a one to one basis. If prescriptions needed collecting or an errand run, the activity co-ordinator did this and took one or two people with them. The organised trips took place less often as they relied on having more staff available which, with the low staffing levels had not always been possible. People's religious needs were respected. For example, one person was supported to attend church every week.

The service had a complaints policy available and people could raise informal complaints with any of the staff. People felt they could speak to any staff. One person was asked if they had ever raised a complaint and said, "No, but if I needed to I would. I would just raise it informally and it would be sorted I'm sure of that." Another person told us they would speak to the registered manager if they had a concern adding "I feel any concern would be answered." We saw complaints which had been raised were dealt with and communication had with the complainant to ensure they were happy with the outcome.

Requires Improvement

Is the service well-led?

Our findings

Although some staff felt comfortable suggesting ideas about how the service could be changed for the better for everyone, other staff also raised there was a tendency for cliques or favoured groups among the staff team which made it less likely they would suggest changes. Also, some staff added they had not been listened to. This was especially important when it came to the issue of staffing. Staff meetings took place on a regular basis and at the last one on the 4 May 2016 staff had raised the issue of needing more staff as people's needs had become more complex. The response from the registered manager and provider had stated they were meeting NICE guidelines and therefore "acceptable". Prior to the inspection we were told of concerns that staffing levels were not safe and having reviewed this we found the registered manager and provider did not have systems in place to ensure there were enough staff to meet people's needs. This meant the quality experienced by people and their safety was being compromised as there were not enough staff to do meet people's needs.

The provider had a range of audits in place including care plans, infection control, medicines, falls and maintenance of the building. However, they did not bring out all the issues identified during the inspection. For example, the provider had not identified in their audit of infection control the risk of staff preparing food and meeting care needs at the same time. In the medicine audit they had equally not identified the issues in respect of staff being interrupted, the ordering of medicines and staff not rotating medicines. The overall falls audit did not analyse the impact on people at the service wide level or looked at any related topic, such as staffing and call bell response times, which may have explained why there was a high fall rate. This meant action had not been taken sooner to address these issues.

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

In response to the concerns raised during the inspection, the provider started to look at ways of improving this straight away. For example, increasing staff numbers and starting the process of how to review people's dependency needs, fall rates and call bell response times.

Shire House Care Home is owned by Sentry Care Limited. This is their only service registered with us. A nominated individual (NI) was appointed to report at the provider level. The NI is a person appointed by the provider to be responsible for supervising the management of the service. The NI is also the registered provider who attended the service on the second and third day of the inspection. There was a registered manager employed to manage the day to day running of the service. They were supported by a deputy and senior care staff.

People and staff could identify who was in charge. Staff felt there was a clear line of accountability and they knew their role and responsibility. One person said, "I do see the [registered] manager, I guess once or twice a week but I'm not aware of any residents meetings." People and relatives said they saw the provider often and felt they could approach them.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations.

The provider had some knowledge of the Duty of Candour (DoC). The DoC states that registered persons must act in an open and transparent manner and apologise when things go wrong. The provider stated they would look at the DoC and ensure all staff were aware of what this meant.

The registered provider had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that for legionnaires and of fire safety equipment took place.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1) and (2)(b) Care was not designed with a view to achieving all people's preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) and (2)(h) Care and treatment was not provided in a safe way as people were not protected from the risk of food poisoning.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) and (2)(a)(b) Systems were not in place to mitigate the risks relating to people's accidents and falls and to ensure there were sufficient staff employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet people's needs safely.