Barchester Healthcare Homes Limited

Sherwood Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Sherwood Court Care Home is registered to provide nursing and personal care for 68 people, some who are living with dementia. People living at the home have varying needs from specialist support and help with everyday living to those who need a helping hand to retain some independence. People can stay on a permanent basis whilst others stay for short periods of time.

The previous inspection took place on 22 June 2015, during which no breaches to the Regulations were identified, and the service was rated as good. This inspection took place on 22 and 25 August 2017. The first day of the inspection was unannounced. The second day was announced.
There was no registered manager in place. 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 previous registered manager had left the service in May 2017. Since then, a regional management team had been at the home, and an acting manager had been in position. However, on 18 August this regional management team had been replaced, and a new management team had been appointed to oversee the home. "'

Our observations and discussions found that people using the service did not always have enough staff available or suitably deployed to meet their assessed needs. Staff were found to very busy, and they felt that they could not always offer people the person centred care that they wanted to. Relatives had concerns that the staffing levels or deployment of staff was unsatisfactory. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations and discussions found that the measures in place relating to the safe handling of medicines, the prevention of risks and the prevention of the spread of infection and cleanliness within the home were not satisfactory. Some areas of the home was found to be unclean, risks around people's behaviour had not been properly assessed and measures put in place to reduce these risks had not been properly addressed. A registered nurse was seen to make a "minor" mistake whilst administering medicines, and as a result the inspector had to intervene to ensure correct procedures were followed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the units within the home was specifically used as a dementia care unit, and we found that the environment and adaptations were unsatisfactory as they did not met the expectations of the current best practice and guidelines relating to dementia friendly environments. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that on occasions, staff interactions with people living with dementia was minimal, and on one occasion, very undignified. This was a breach of Regulation 10 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014. People using the service must be treated with respect and dignity at all times.

Our evidence gathering and observations found that there had been a lack of management oversight within the home overall in the last six months. This had led to some people being exposed to potentially avoidable risks, and that good governance issues such as effective infection control measures, risk assessment, record keeping, staff deployment and morale, audit and monitoring systems had not been routinely been addressed. As a result, the systems and processes that enabled the service provider identify and assess risks to the health and welfare people who use the service were not satisfactory. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always receive support through effective supervision and appraisal. We recommended that this be given priority so that individual staff members could use the process to develop both personal and service led goals and objectives.

For some people living with dementia, their access to activities during the day was limited, and we recommended, that improvements were made to ensure that people's social and intellectual needs were met.

We reviewed recruitment practices and found that all staff had the required pre-employment checks including DBS and references. All files we looked at had the required information under schedule three of the Health and Social Care Act 2014.

Relatives we spoke with were happy with how their loved ones medicines were managed. We saw that controlled drugs were managed in line with the best practice guidelines and medicines were counted and checked as required.

Staff we spoke with told us they received a variety of training via different methods of learning such as classroom based, e-learning and by completing work booklets. We saw evidence within staff files of training certificates and reviewed the homes training matrix. However, we recommended that the service revisit the national guidance on catheter care, and considered how they could provide appropriate training to nurses in relation to catheter care, and other healthcare issues if needed, in order to ensure people's needs were effectively met.

The home was working within the principles of the Mental Capacity Act 2005. They had carried out appropriate assessment of people's capacity to determine if they could make specific decisions. Assessments were based on specifics and where necessary specific best interest decisions were made and recorded. People we spoke with told us they knew how to raise issues or make complaints. They also told us they fell confident that any issues raised would be listened to and addressed.

You can see what action we told the provider to take at the back of the full version of the 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.

Relatives and staff raised concerns about safety in the home.

Staffing numbers were not always sufficient to meet people's needs. There was not always a consistent approach to the care and support provided.

Medicines were managed by staff who had received training in how to administer medicines safely; however, some minor issues were identified.

People's health and welfare were not always promoted through the use of effective infection control measures that were followed, audited and monitored.

Is the service effective?

Requires Improvement

The service was not always effective.

People who used the service said staff were knowledgeable about their needs, however, staff supervision and appraisal was not always effective.

The living environment on the dementia care unit was not adapted to meet the needs of people living with a dementia.

People's rights were protected and promoted by staff who were aware of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People said the meals provided were good and they could choose from a number of different options.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff engagement and interaction in some instances was limited and in once instance undignified. The lack of attention relating to cleanliness meant that people lived in an environment that was

undignified.

People who used the service and their relatives spoke positively about the staff and the care they provided, however, they believed the staff to rushed.

Systems were in place to support people at the end of the life, and their needs and wishes relating to end of life care were appropriately assessed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although staff wanted to provide care and support that was person centred, their deployment within the home could have a detrimental impact in achieving this goal.

Effective social activities were not always provided for people which enhanced their well being.

People were able to talk to staff and raise any concerns they may have.

Is the service well-led?

Requires Improvement

The service was always well led.

There was no registered manager in place.

Staff and relatives said that morale was low.

The management systems in place to regularly check the quality and safety of the service had not always been effectively implemented in recent months.

Risks to people's safety and dignity had not been effectively identified and talked to bring about improvement.

Sherwood Court

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 first day of the inspection took place 22 August 2017 and was unannounced. We returned to undertake further inspection activity on 25 August 2017 the second day as announced.

The first inspection day was undertaken by the lead inspector for the service, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a nurse with particular experience in mental health care and support. Experts-by-experience are people who have personal experience of using or caring for someone who uses health, mental health and/or social care services that we regulate.

We spent time speaking with and observing people who lived in the home, and staff in the communal areas of the home. We spoke with people in private. The home is divided in two units. The ground floor caters for people living with dementia, and the first floor caters for people with physical nursing needs. As many of the people living on the dementia care unit live with varying degrees of dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We were able to see some people's bedrooms, bathrooms and the communal bathrooms. Meal times were observed throughout the two days.

We looked at care records for six people living in the home across the two floors. We also looked at their medicines records, their risk assessments and care plans. We observed medicines being handled and discussed medicines handling with staff. We spoke with 15 people living at home over the two day inspection, nine relatives or visitors and 12 members of staff including the acting manager and regional manager.

Prior to our inspection we checked our records relating to the service, reviewed the notifications we had received from the service, the service's Provider Information Return (PIR) and reviewed the safeguarding

referrals that had been made relating to people who lived at the home. The PIR is a document completed by the provider that provides CQC with data, and some written information about the running and development of the service.

Requires Improvement

Is the service safe?

Our findings

The relatives of people who used the service said that they thought staffing levels were sometimes "Inadequate to meet people's needs." One person said, "They [the staff on the dementia care unit, don't always appear to have the time to provide assistance to people without delays. I have found my [relative] to be soaked in urine on a few occasions, and when I have spoken to the staff, they say that that they were too busy to help them get to the toilet in time." Staff we spoke with said that there were times when there were delays in the provision of personal care such as supporting people to use the toilet, but they believed these delays were few and far between, One staff member said, "We do respond to people's requests to use the toilet, but there may be times when we are so busy that people have accidents. This is not an ideal situation, and we have tried to explain these problems to senior staff."

Another relative said, "My [relative] loves to spend time with people: they love to chat and sing, and just be close to people. The staff are so busy that they just don't always have the time to give them this type of attention. The staff just about have the time to help people get up, get washed and dressed. They then have to move onto the next person. Once everyone is up, then they have a lot of other jobs to do, and offering people a little bit of TLC (Tender Loving Care) or one to one support is very rare. The staff are very dedicated, but there is either not enough of them, or they are not being led properly."

We observed the interactions between the staff and people at the home on both the dementia care unit, and the nursing care unit, and found that on the whole, these were generally positive. However, we did note that staff on the dementia care units were seen to be very busy. Once one person had been supported with personal care, or support with meals for example, then the staff moved onto the next person. One staff member said, "We are always run off our feet, but that might be the nature of the needs of the people we work with. But, we do find that there is frequently not a lot of time to give people real one to one attention. We are very "task" oriented. We understand that jobs need to get done, but I would like to be able to give people more attention."

Staff on the nursing care unit said, "The needs of the people on this unit are very different to those on the dementia unit. I think we are just as busy: just busy in different ways." We asked what the differences were, one nursing care staff member said, "On the dementia care unit, people are constantly asking for or looking for support, whereas on this unit, we have more of a set routine that doesn't really change. It helps when planning the shift."

Another staff member said, "It can be very stressful as there are minimal staff numbers most of the time. We do our best but there is no time to spend with residents. Basically, we do the bare minimum, and try and keep people safe."

Staff told us some people were unable to use their call bell and needed regular checks, however they did not always have sufficient numbers of staff to do this. One relative said, "The staff on the dementia unit sometimes ask me to watch people whilst I'm visiting, so that they can pop out and do a job." We reviewed people's records and found some gaps in the monitoring sheets for hourly checks. Some people needed

repositioning at least every four hours and we also some found gaps in these monitoring sheets. The dementia care nurse told us staff were repositioning people as needed, but they didn't always have time to record it. The acting manager said that he had identified issues relating to document recording, and explained that new documentation was to be introduced, and action such as supervision and training, to ensure that staff completed records.

The service was seen to use an assessment tool to identify the dependency needs of the people living at the home, and link this to the numbers of staff needed on each shift. The regional director explained that the Dependency Indicator Care Evaluation (DICE) tool needed to be revisited in order to ensure that the information held within it was accurate. She added that the staffing rota was in the process of being evaluated in order to ensure that it was flexible enough to ensure a better deployment of staff so as to meet the assessed needs of people living at the home.

Our observations and discussions found that people using the service did not always have enough staff available or suitably deployed to meet their assessed needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely. Fridges were available to store those medicines that required it and the temperature was checked and recorded daily. Medicines were administered by the registered nurses who had received training in this area. People's photographs were attached to their Medication Administration Record (MAR) sheets to aid identification and any medicine allergies were recorded. Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited and documented by the nurses to check that records and stock levels were correct.

However, we noted that the medicine disposal containers were very full, and we were told that this was due to a clause in the contract that the service had with the pharmacy, which meant that medicines were only collected every three months. The acting manager explained that contact would be made with the pharmacy in order to renegotiate the terms and conditions.

We observed a medicine round taking place on the dementia care unit. At one point, the nurse dropped a tablet, and rather than picking it up and disposing of it, they proceeded to try and give it the service user. An inspector intervened just before the tablet was given. Although the nurse was seen to be nervous whilst being observed undertaking a medicine round, there was an expectation that they should be able to follow recognised guidelines, and undertake the task without making mistakes.

Although there were policies in place in relation to safeguarding and whistleblowing procedures which guided staff on any action that needed to be taken, there were instances when people were not safeguarded. Records showed staff had received training in safeguarding adults, however, our observations showed that this training was not being put into practice. Discussions with staff showed that they were aware of their responsibilities and they were able to describe to us the different types of abuse and what might indicate that abuse was taking place. However, our evidence indicated that that the staff understanding how to safeguard people effectively was poor.

During the observation of lunch, we noted that a person who was living with dementia, picked up a piece of cutlery, and proceeded to approach another person, and attempted to stab them. A staff member was close by, and quickly intervened. We spoke to a relative who explained that earlier in the week; a similar incident had taken place, where a person living with dementia had thrown a knife at their relative. The knife had hit the person and their arm, but had not caused an injury.

Another relative explained that there were some people living on the unit who got very confused about which bedroom was theirs. They explained that there had been times when one male resident had entered their female relative's bedroom. Although the relative understood the reasons why this occurred, they said that it was a cause of concern as the male resident had been seen to be agitated and aggressive in the past.

The staff we spoke with told us that due to their minimum numbers, they weren't always confident that they could always keep people safe. One person said, "There are times when some residents move around and do their own thing. This is good, but we can't be everywhere, all the time. There may be times when people enter the wrong room, or even that some people end up arguing. It can be very difficult to monitor and observe everyone."

Our observations and discussions found that the measures in place relating to the safe handling of medicines and the prevention of risks were not satisfactory. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate measures were not always in place to maintain standards of cleanliness and hygiene in the home. For example, even though there was a cleaning schedule which all housekeeping staff were expected to follow, the dementia care unit was not free from odours and was visibly unclean. The management team explained that since their arrival at the home, they had introduced a new cleaning regime, and we saw evidence of this taking place.

Staff explained that although they had access to stocks of personal protective equipment such as gloves and aprons, they regularly ran out of wipes. This meant that they had to use flannels. These flannels were then sent to the laundry for washing.

Our observations and discussions found that the measures in place relating to the prevention of the spread of infection and cleanliness within the home were not satisfactory. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records showed that people's individual needs were assessed before admission into the home and where risks were identified appropriate guidance was in place to minimise potential risks. For example, the provider had carried out assessments in relation to falls prevention, pressure ulceration, nutrition and the safe moving of people. Personal fire evacuation plans had been completed for people using the service that would support the emergency services in the event of an evacuation of the home. There were contingency plans in place to ensure peoples safety in the event of an untoward event such as accommodation loss due to fire or flood.

Risks to people's health and wellbeing were identified and guidance was provided in the home to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, mobility and safety, nutritional risks and where required risks around peoples inability to be able to use the call bell to request assistance. Risk assessments included information about any action staff needed to take to minimise the possibility of harm occurring to people.

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been completed including obtaining written previous work and personal character references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be

unsuitable to work with people who use care service. Nurses who wish to continue to practice in their role must register with the Nursing and Midwifery Council to keep their skills and knowledge up to date. We could see that nurses were meeting the requirements of their role and regularly renewing their registration to evidence they remained competent to continue.

Requires Improvement

Is the service effective?

Our findings

We spoke with some of the staff and relatives about the design and environment on the dementia care unit. Some staff thought that although the décor was pleasant, there wasn't a lot of objects or stimuli for people to use when they moved around the unit. We found that there was a lounge with a TV in it, and objects for people to pick up and look at, but no items or stimuli either on, or at the end of corridors. There were also three small lounges that at the time of our visit, were being used as dining areas due to the refurbishment of the main dining room and lounge.

One relative explained that the main dining room and lounge had been closed for nearly three weeks as it was being refurbished and redecorated, and this was why the small lounges were being used as dining areas. The regional director explained that the refurbishment of the main dining area had not been started and completed on time, and she recognised that this was not an ideal situation, as it had a potentially negative impact of people at the home. Upon her arrival at the home, she had quickly put a plan into place to ensure that the dining room was quickly completed. We saw on the second day of our inspection people using the dining room during the lunchtime period. Staff said that people seemed happier as the environment was a lot better.

A relative said that they thought the signage on the unit was inadequate. We found that although toilets and bathrooms doors had written signage on them, these signs were small in design, and would have benefitted from better use of pictorial signage. We also noted that the bedroom doors were the same colour as the walls: this could lead some people with perception difficulties to find the distinguishing of doors and walls difficult.

The regional director explained that the service provider, Barchester, had a system in place to ensure care environments were dementia friendly. She said that this system known as 10-60-6 would be used at Sherwood Court to determine how the environment could be improved. As the unit is specifically used as a dementia care unit, we found that the environment and adaptations were unsatisfactory. The 10-60-6 system should be used as a matter of urgency to ensure improvements to the living environment are made, and that the environment is adapted to meet the assessed needs of people living with dementia. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff at the home said that they received training to do their jobs. One staff member said, "Since starting 12 months ago, I have done my induction, and attended a few other training events. I have noticed in the last few months that training has become a bit of a rare event. I think this is because of some of the changes in management." Another said member who had been at the home for only six months said, "I've been on all the important training such as health and safety and moving and handling. I think the training has been ok."

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals, such as a chiropodist or tissue viability. However, following our inspection, we also spoke to a visiting health and social care professional who explained that they had concerns over how the service dealt with catheter care. They explained that as most of the nurses

at the home, had received training in catheter care, however, there were times when the service was found to access the district nursing team to provide appropriate services to people assessed as requiring continuing healthcare support.

We spoke with the acting manager and clinical lead at the home following our inspection visit, and explained that this would be appropriate for people assessed as not requiring continuing healthcare. However, for people assessed as requiring continuous healthcare, then the expectation would be that nurses at the home would provide this type of healthcare. The clinical lead confirmed that the nurses who had not received training in this area would be as a matter of priority, and that appropriate guidelines would be followed when dealing with catheter care.
We recommend that the service revisited the national guidance on catheter care, and consider providing appropriate training to nurses in relation to catheter care and other healthcare issues, in order to ensure people's needs were effectively met.

Information held with the staff personnel files showed that new staff completed an induction programme which included shadowing more experience staff. We found that there were systems in place to identify when staff needed to repeat areas of training to ensure they maintained up to date skills and knowledge. Staff training figures were monitored carefully and when it was identified that any staff member's mandatory training was out of date, this was raised appropriately through supervision. There was a detailed competency framework in place for all nursing staff.

The regional director had a policy for the supervision and appraisal of staff. Although staff told us that they saw supervision as an opportunity for them to discuss their performance, training and well-being, they said that supervision was infrequent, had been used to raise performance issues rather than staff development. Some of the records we looked at confirmed this. Staff confirmed that appraisals took place, and involved the review of their performance, but said that future goals and objectives were not normally an essential element of the process. Again, the appraisal records we looked at confirmed this.

We recommend that staff support through effective supervision and appraisal is given a priority so that individual staff members can use the process to develop both personal and service led goals and objectives.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that where people lacked the capacity to consent to their care and treatment, the provider had completed mental capacity assessments. We found the capacity assessments mentioned family members had been consulted. The management team had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. We found that some applications had been authorised but some were still waiting for an assessment from the local authority. The applications

which had been authorised had best interest assessments in place. The management team had systems in place to ensure the service was complying with conditions applied to the authorisation.

Some people had advanced care plans in place to identify what medical treatment they wanted to receive in the home or when they wanted to be admitted to hospital. This also included who they wanted to be involved in any decisions in an emergency if they were unable to do so.

Requires Improvement

Is the service caring?

Our findings

We looked at a range of issues that had an impact on people's privacy and dignity. We saw that appropriate locks were in place in areas where privacy was required, e.g. bathroom and toilet doors, and bedrooms. We found that these could be overridden in the event of an emergency. We noted that modesty was promoted and achieved for people moving between different areas within the home e.g. bedroom to bathroom. Relatives confirmed that private areas and time were available for them when they visited.

However, we noted an agency staff member was working with a person who was living with a dementia on a 1:1 basis. The agency staff member escorted the person around the home, and ensured that they were kept safe. We observed the interaction of the staff member for 20 minutes, and noted there was no meaningful communication taking place during this period. We saw only one occasion that the staff member spoke to the person which was when they were offered a cup of tea. The staff member pointed to the cup of tea and said, "sit" to the person living with dementia. This was not a dignified way of speaking to the person, and this incident was reported to the nurse of duty, and the regional director, who agreed with our observations, and said that they would speak to not only the agency staff member, but also all the staff in relation to the need for dignified interactions with people living at the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service must be treated with respect and dignity at all times.

Some people required items of equipment such as mobility aids or adapted crockery to support them to be independent. We saw that the staff on duty knew the items people needed and ensured these were provided as they required. However, some items of mobility equipment were found to be in need of a deep clean. Other areas of the home were found to be unclean, and this was not seen to be a dignified way of living. In order to promote and protect people's dignity, we have made a requirement that cleanliness in the home is maintained and monitored.

We saw, and people told us, that the staff supported people to maintain their dignity and privacy. They ensured people were appropriately dressed, and staff supported people to maintain their personal appearance. We noted that when possible and depending on their needs, people were encouraged to carry out tasks for themselves such as washing, dressing and eating. We saw that the staff made sure doors to private areas were closed when people were receiving support with their personal care.

We found that people's care plans contained individual communication plans, which included guidance on the ways they expressed themselves if they did not communicate verbally. People's confidential information was kept private and secure and their records were stored appropriately. The staff we spoke with knew the importance of maintaining confidentiality and had received training on the principles of confidentiality.

Staff at the home knew how to contact local advocacy services and the Independent Mental Capacity Advocacy service if people living at the home required independent support to make important decisions about their life. One relative we spoke with said, "Information regarding advocacy services is available, and I

have used them for advice."

Requires Improvement

Is the service responsive?

Our findings

One relative we spoke with said that they had been consulted about how they thought their relative should be cared for as they were living with a dementia and were unable to express themselves. Another said, "The staff are usually very good at working out how best to care for people. They put this information in the care plan, and check it with me to make sure it is right."

We saw that the planned activities were displayed on posters at the entrance to the home and on display boards around the home. Activities on the nursing unit were seen to take place, and people were seen to engage in these activities. However, we noted that the activities coordinator from the dementia care unit had recently left the employment of the home. This meant that there were very few activities on offer to people on this unit. One relative said, "There's not really a lot to do on the dementia care unit. When I visit I watch a lot of TV with my [relative], and we sit and talk, but that's about it. We sometimes get entertainment in, and in the run up to Christmas, things normally improve."

The regional director and acting manager explained that they were aware of the need to make improvements to the activities on offer at the home, and that this formed part of their action plan for the home.
We recommend that an assessment of activities on offer at the home does take place, and where needed, improvements made to ensure that people's needs are met.

We had the opportunity to speak to a visiting health care professional. They did not question the accuracy of the recordings in the care records, but did say that some the records were sometimes not consistently completed in a timely fashion. Staff at the home said that although they strived to complete the records in a timely manner, they sometimes had difficulties due to their work load. The regional director explained that a new recording system was to be introduced in order to ensure a consistent approach.
We recommend that appropriate recording systems are put into place and monitored effectively.

Each person had a care plan. Care plans seen provided detailed information about the needs of the person, and some contained one page profiles which enable staff to access a brief overview of someone's daily needs and preferences, as well as any risks relating to their health or wellbeing. The regional director explained that measures were in place to ensure one page profiles were completed as a priority so that the staff could really get to know people. We saw care plans were reviewed and updated when necessary. Relatives we spoke with confirmed that they were invited to attend any reviews for their relative, which could be arranged at a mutually agreeable time.

The regional director had a procedure for receiving and responding to complaints. A copy of the complaints procedure was displayed at the entrance to the home. This meant it was available to people who lived in the home and their visitors if they wished to make a complaint. People told us that if they had a concern, they would raise this with the staff on duty or with one of the management team. Records held at the service showed that when complaints had been raised, they had been dealt with in a timely manner and that the complainants were satisfied with the way the issues had been resolved.

Requires Improvement

Is the service well-led?

Our findings

The general consensus from staff at the home, and relatives was that in recent months, the standard of leadership and general management within the home had declined. Staff at the home said that morale had been very low over the previous three to four months. One person said, "A lot of staff have come and gone, and we do rely on agency staff. This can put a lot of pressure on permanent staff because you need to mentor people, and make sure that they know people's needs. Having to do this every other day is hard work." A relative who regularly visited the home said, "I don't think there has been any clear leadership from managers or senior staff for some time. I wouldn't say that standards have declined to rock bottom, but people are under a lot of pressure, and they sometimes let things slip."

The regional director and acting manager were able to offer some explanation for this. There had been no registered manager in place, as the registered manager left the home in April 2017. A regional management team was then placed within the home to oversee the day to day running of the service, and recruit a new manager. We found that this original management team had been removed from the service the week before our inspection visit, and that a new management team had been installed.

Since starting at the home on 18 August 2017, the new management team had commenced work on completing the refurbishment of the dining room and lounge on the dementia care unit, had undertaken an infection control audit and instigated a new cleaning regime. We also found they had started to look at all the major systems within the service to determine how improvements could be made to raise quality and ensure people's needs were effectively met. They had identified areas that needed improvement such as staff deployment, environmental factors, staff training and supervision and staff leadership.

In an attempt to provide this clear leadership to the staff, a regional manager had been promoted on the day of our visit to senior regional manager, and they had taken over as acting manager of the service. The regional director for the service confirmed that this person would apply to be registered with the CQC.

We saw some examples of internal meetings that had recently taken place, and helped to assess the performance and quality of the service. Areas such as the environment, staff 1-1's and resident's reviews had been discussed. Care planning, safeguarding issues, food, health and safety and complaints and compliments had also been discussed. We saw a selection of audits which showed that the new management team had started to look at how the service operated, in order to determine where further improvements were required.

It was clear that only a limited amount of quality audits and checks had taken place over the previous six months (since the previous registered manager had left the company). The acting manager explained that a full range of quality checks were now in place, and a full action plan had been developed in order to address areas of service development and improvement. We saw a draft of this action plan, and found that it was comprehensive, with clear action points delegated to various members of the management team.

We saw that an employee of the month award was in place, and the regional director said this would be

used to recognise individual staff performance, in order to boost their confidence, and hopefully staff morale.

Our evidence gathering and observations found that there had been a lack of management oversight within the home overall the last six months. This had led to some people being exposed to potentially avoidable risks, and that good governance over issues such as effective infection control, dignity, risk assessment, record keeping, staff deployment and morale, quality audit and monitoring had not been routinely addressed.

As a result, the systems and processes that enabled the service provider identify and assess risks to the health and welfare people who use the service were not satisfactory. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clearly displaying the latest inspection rating both on line and within the home itself in line with their regulatory responsibilities. There were no issues with the home notifying the CQC of incidents.

We looked to see how the provider actively sought the views of a people who used the service. We found that the service had a feedback system were people could comment about their experience of, and the quality of care and support delivered by the service. This information showed that people were positive and generally happy with the services provided. However, the data was 12 months old, so did not take account of the latest issues to face the home.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Despite observing poor staff interaction on only one occasion, the nature of interaction was sufficient to show the people's dignity was not maintained, and that measures must be put in place to ensure that positive staff engagement is encouraged at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Our observations and discussions found that the measures in place relating to the safe handling of medicines, the prevention of risks and the prevention of the spread of infection and cleanliness within the home were not satisfactory.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Our observations and discussions found that the measures in place relating to the prevention of the spread of infection and cleanliness within the home were not satisfactory, and put people at risk. The environment and adaptions on the dementia care unit were unsatisfactory, and did not meet the expectations of current guidelines and best practice in relation to promoting independence, choice and well being for people

living with a dementia.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Our evidence gathering and observations found that that people had been exposed to potentially avoidable risks, and that issues such as effective infection control measures, risk assessment, record keeping, staff deployment and morale, audit and monitoring systems had been routinely been address in recent months. As a result the systems and processes that enabled the service provider identify and assess risks to the health and welfare people who use the service were not satisfactory.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Our observations and discussions found that people using the service did not always have enough staff available or suitably deployed to meet their assessed needs.