Coverage Care Services Limited

Coton Hill House

Inspection report

Berwick Road
Shrewsbury
Shropshire
SY1 2PG

Tel: 01743235788
Website: www.coveragecareservices.co.uk

Date of inspection visit:
20 October 2016
24 October 2016

Date of publication:
22 December 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?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 20 and 24 October 2016 and was unannounced.

The home was last inspected on the 1 and 3 September 2015 where it was rated as requires improvement. At the last inspection the provider needed to make improvements to governance systems, staff deployment and training. At this inspection we found that improvements had not been made and other areas of the service now needed further improvement.

Coton Hill House is registered to provide accommodation with personal care for up to a maximum of 45 people. There were 44 people living at the home on the day of our inspection. People were cared for in five units over two floors. The Cherry and Berwick units were on the ground floor. The River View, West View and Castle View units were on the first floor. Some people were living with dementia.

There was a registered manager in post who was present during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a lack of effective leadership in the home that failed to give staff direction to recognise the needs of the people using the service. We found a lack of management oversight with regards to people's care plans and staff practice. As a result people's health and wellbeing was compromised.

The provider had systems in place to assess and monitor the quality of the service provided but these were not always effective in identifying shortfalls.

People were placed at risk of harm by staff who sometimes used unsafe moving and handling practices. Risk assessments did not always reflect the support people received or required to meet their needs and staff did not always know how to support people effectively. People did not always get the support they needed when they needed it because there were not enough suitably trained staff deployed to meet their needs.

People's rights were not always protected when they could not consent to their own care and treatment. Decisions that had been made on behalf of people were not always recorded to show how and why they were in their best interests.

We found that people were not always with respect, dignity or consideration. This was particularly evident in the Castle View unit where people's care and emotional needs were not consistently being met.

People were not always provided with care and support that was individual or personal to them. Staff did

not manager people's anxieties well and this caused distress to them and other people.

The provider encouraged people, relatives and staff to give feedback about the service and used the information gathered to make improvements.
People's nutritional needs were routinely assessed, monitored and reviewed. People were offered a choice of what they wanted to eat and enjoyed the food. Where required people were provided with support to eat and drink.

People were spoken to in a kind and polite manner. People were able to choose how they wished to spend their time. Whilst some chose to sit in the lounge others liked to have some private time in their rooms.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 consistently safe.

There were not enough suitably skilled staff effectively deployed to meet people's changing needs.

People were not always protected from harm because staff did not help them to move around safely.

People were supported to take their medicines as prescribed to maintain good health.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health needs were not always effectively managed by staff.

Where decisions had been made on people's behalf we could not be assured these were always in their best interest.

Staff felt well support by management and other staff.

People had a choice of what to eat and drink

Is the service caring?

Inadequate

The service was not always caring.

People did not always receive care and support that protected their dignity.

Staff did not manage people's anxieties well and they became distressed.

People were not always given choice.

People were supported to maintain contacts with friends and relatives who were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support that was tailored to their needs.

Staff knew people well but there was a lack of activity that was individually planned for people.

The provider had a clear complaints procedure which was followed.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of effective leadership in the home that failed to give staff direction to recognise the needs of the people using the service.

Systems that the provider had in place to monitor the quality of care were not effective.

The provider encouraged feedback and used the information to make improvements in the service.

Coton Hill House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 and 24 of October 2016 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service, such as statutory notifications we had received from the provider. Statutory notifications are about important events which the provider is required to send us by law. We asked the local authority and Healthwatch if they had information to share about the service. We used this information to plan the inspection.

During the inspection we spoke with nine people who lived at the home and one relative. We spoke with ten staff which included the registered manager and nine care staff. We spoke with one health care professional by telephone following our inspection. We viewed five records which related to the assessment of needs and risk. We also viewed other records which related to the management of the service such as medicine records, accident reports and complaint records.

On the second day of our inspection the provider had commenced work on the planned refurbishment of the home. The West View unit communal area was closed and people were moved onto to other units and the provider's onsite day care centre during the day.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk with us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection the provider needed to make improvements to the way in which they deployed staff to meet people's needs. At this inspection we found improvements had not been made. People did not always get the support they needed when they needed it because there were not enough suitably trained staff deployed to meet their needs. One person told us, "They (staff) say in a minute and minute never comes." Another person said, "You sometimes have to wait for support." A further person told us, "Have to wait a lot sometimes." Some staff told us they felt there were enough staff to safely meet people's needs and that they had time to talk or engage in activities later in the day. However, other staff felt there were times that more staff were required due to people's needs. One staff member told us they needed more staff on the Castle View unit as they were unable to leave the unit unattended as, "People often had fall outs with each other." We found that because there were not enough staff available to support people when they became upset this caused further distress to them and other people became upset.

On the first day of our inspection a student from the college was left alone on the Cherry Unit for an hour and a half to care for people they knew nothing about. The registered manager said this should not have happened but staff we spoke with told us they had "beds to do." and couldn't stay with the student.

We spoke with the registered manager about the staffing levels at the home. They told us the provider had recently increased staffing levels at night to meet people's needs. They had also arranged additional staffing to support people during the refurbishment of the home. During our visit we saw that some people required frequent observation to ensure their safety and the safety of others. In addition to this they had door or floor alarms in place to alert staff when they were leaving their bedrooms during the night. Despite these protective measures staff told us they locked one person in their bedroom. They did this because they could not ensure that staff would be available to respond to the alarms in enough time to stop other people entering the person's bedroom.

We found that meal times were chaotic as staff did not have the skills or capacity to manage both people's physical and emotional needs. We observed that staff had little time to engage with people apart from when they were completing tasks with them. The registered manager could not assure us the systems they had in place to determine people's level of need and subsequent staffing ratios were effective. The registered manager acknowledged that they needed to review people's needs and the deployment of staff.

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

We found people were not always supported to move around safely. We saw two occasions when staff did not follow safe practice or guidance in people's care plans when supporting them with their mobility. This placed both the people and staff at risk of serious injury. We saw two staff members complete an underarm lift (drag lift) when supporting a person to stand. We spoke with the staff about this, they told us they knew this type of manoeuvre was unsafe and they were not allowed to do it. In the second instance we saw two care staff manually lift another person to sit upright in their arm chair. When we spoke with the staff they

told us they knew they were not supposed to manually lift the person but could not use the hoist as the person was sat on a pressure relieving cushion. Later on the same day we saw that the same person was safely moved with the use of the hoist by the same staff member and a senior staff member whilst the pressure relieving cushion was in place. We brought these two examples to the attention of the registered manager who said they would take action to prevent reoccurrence.

Staff we spoke with demonstrated they would take appropriate action to support people who had had an accident such as, a fall. We saw that they took immediate action to ensure people's safety as well as completing the accident reports. For example, we saw in one person's records that they had fallen during the night on three separate occasions. Staff had checked the person for any signs of injury following each fall. They subsequently monitored the person over the next 24 hours to ensure their wellbeing. Senior staff had updated the person's risk assessment and contacted the GP to establish whether there was any physical cause for the falls. Other staff we spoke with were able to tell us about the risks associated with people's care and the action they took to minimise this. These included people's risk of falls or not eating and drinking enough. We saw that some people were on half hourly observations to ensure their safety and wellbeing was maintained.

We observed that staff did not effectively manage or consistently report incidents between people. On both days of our inspection we witnessed verbal altercations between people who lived on the Castle View unit. Staff who worked on this unit told us there were daily incidents between people but we found this was not reflected in people's care records or incident forms we looked at. We therefore could not be assured that all incidents were recorded and analysed to prevent reoccurrence.

Staff had received training and understood how to recognise any signs of abuse. Staff told us they had access to the policies on how to keep people safe from abuse. They knew how to report concerns if they witnessed or became aware of abuse taking place. One staff member told us, "I would report it straight to the manager or use the whistleblowing policy." We saw that the provider had made appropriate referrals and completed investigations in consultation with the local authority safeguarding team where necessary.

Staff told us the provider had completed checks to make sure they were suitable to work with people living at the home. These included references from previous employers and Disclosure and Barring Service (DBS). The DBS helps employees make safe recruitment choices. Records we looked at confirmed that the provider followed safe recruitment procedures.

People told us they were supported to take their medicine as prescribed. Staff made sure people had a drink of water to help them take their tablets or to wash away the taste of their medicine. Staff remained with people to ensure they had swallowed their medicine. We saw that one person spat out their medicine and this was appropriately disposed of and recorded. The staff member explained that the person was starting to have difficulty swallowing they therefore were going to request oral medicine for the person. We later checked the person's records and saw that the staff member had informed the registered manager who had contacted the GP to action this.

The provider had recently moved over to electronic medicine administration records. Staff told us they had been given training and support on how to operate the new system. Staff were only able to administer medicine after they had received training and were assessed as competent. They then had subsequent competency assessments to ensure the ongoing safe management of medicines.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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 the principles of the MCA were not consistently applied. When a staff member showed us around the home they told us that staff locked one person's bedroom door at night. They did this because some people walked around during the night and the person was unable to alert staff if other people entered their bedroom. The person did not have the mental capacity to consent to the door being locked and a best interest's decision had not been completed. As well as potentially depriving the person of their liberty, the closed door meant that the person was socially isolated. The registered manager told us that staff had not made them aware that this practice was taking place. They subsequently completed a mental capacity assessment and best interest decision to support staff practice of locking the person in their bedroom. We were not assured that the person's rights had been protected or that staff had considered the least restrictive option. In another person's care records we saw that a relative had signed consent forms in relation to the management of medicine and health without the legal authority to do so. When we spoke with the registered manager they understood that the relative should not have signed the consent form and had not been made aware that they had been asked to do so.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At the last inspection the provider needed to make improvements to ensure staff received adequate training to meet the needs of people living at the home. At this inspection we found the provider's systems to monitor the quality of their training and staff application to practice was ineffective. They had not ensured that staff had the required skills to meet people's needs. Some staff told us they felt they would benefit from further training in dementia and how best to manage challenging behaviour. One staff member explained that they had been hit by a person who had become anxious and were shaken by their experience. While senior staff ensured their wellbeing they said they would like the opportunity to do further training to better understand how to recognise and diffuse such situations.

We observed that staff lacked the knowledge and skills to effectively support people with challenging behaviour. When we spoke with the registered manager they told us they were no longer following the 'Butterfly' approach to dementia care in its entirety. This is a person centred approach to dementia care that

involves putting the person and their families at the heart of all decisions. This enabled staff to understand people's individual experience and the most effective way of supporting them. The registered manager told us all staff completed a basic level of dementia training in their induction but the provider was sourcing more in depth dementia training for staff. The registered manager acknowledged that staff would benefit from training on how to manage challenging behaviour.

The registered manager told us they had recently changed training providers and had a range of eLearning in place. They also had face to face training and the deputy manager was a manual handling trainer. Where staff had additional learning needs such as, dyslexia these were catered for on an individual basis. This was confirmed by staff who we spoke with.

Staff told us they felt supported in their roles, they had regular one to one meetings with their seniors and were able to approach them at any time. New staff we spoke with told us they had received a structured induction. As well as a corporate induction where they learnt about the company and the policies they worked to, they received essential training to enable them to fulfil their role. They also worked alongside experienced staff and until they were confident and competent to work independently. One new staff member said if they were unsure of anything they could ask staff or management for guidance. The registered manager told us they enrolled new staff on the care certificate following their three months' probation period. The care certificate is nationally recognised qualification that provides training on the standards of care required of staff.

People's health needs were not always effectively managed by staff. One person had recently been prescribed compression stockings by the GP to treat their swollen legs. We observed they were not wearing them throughout the first day of our inspection. The person's care plan and daily handover notes recorded that the person needed to wear their stockings. We asked a member of staff why they did not have them on, they told us the person had been incontinent and they did not have a clean pair to put on.

We observed that 15 people had swollen legs. One person was not wearing socks because their legs were swollen. We saw a staff member attempting to put socks on them but could not as the socks were too tight. Another person's legs were particularly swollen and their footwear was very tight causing significant indentation to their skin. We pointed this out to a member of staff who said they would support them to put on more comfortable footwear. Later the same day the person was wearing the same footwear. A staff member told us they had adjusted the strap to make them looser. When asked if they had considered encouraging the person to elevate their legs to reduce the pressure of the swelling, we were told the person would not tolerate this. However, we later saw them sitting with their legs elevated and likewise on the second day of our inspection. The duty manager showed us the person's care records had been duly updated following our discussion with them.

We found one person's continence had not been effectively managed. The registered manager checked the person's care records and was unable to confirm whether the person had been referred to the continence service. They agreed to make contact with the district nurses. On the second day of our inspection we saw that the person's needs had been reassessed and new continence products were being trialled.

People who we spoke with told us they were able to access the GP and opticians as and when they needed to. This was confirmed by a relative who told us that staff took care of their relative's health care needs. The registered manager told us that they had good working relationships with health care professionals that supported the home. This was confirmed by a health care professional we spoke with.

People's nutritional and dietary needs were routinely assessed, monitored and reviewed. Where there were

concerns about the amount people ate and drank, staff showed us that food and fluid charts were completed to monitor their intake. Some people required soft diets and thickened fluids, we saw that their needs were catered for.

One person told us, "I get such good food here." People told us and we saw they were offered a choice of what they wanted to eat and drink. We saw that people's lunchtime experiences differed across the home. We were told that there were two lunchtime sittings. The first sitting catered for people who required staff support to eat. The second sitting was for people who were able to eat independently or required minimal prompting and this was usually served half an hour later. We saw that some people were sat at the table up to half an hour earlier than food was ready to be served. Some people who were on the second sitting became anxious and were asking where their food was. One person reached out to take the food from another person. We also saw that staff practice varied when supporting people to eat. Some staff made this a social event chatting with the person as they helped them eat. Whereas in other instances we saw limited interaction between the staff members and the people they were supporting.

Inadequate

Is the service caring?

Our findings

People were not always treated with dignity and respect. One person told us, "I don't like it here! The staff are ok, different staff have different attitudes and manners towards you, some respect you some don't." We found that some people's continence needs were not well managed and their dignity was compromised. We saw that one person had been incontinent and was walking around the home in wet clothing. We saw a staff member stop and speak with the person, they did not help them but carried on walking past them. We asked the member of staff why they had not taken action to wash and change the person. The staff member 'tutted' and walked back to the person and took them to get changed. On the West View unit one person said they were cold and a staff member replied, "The trouble with you [Person's name] is that you are nesh (sensitive to the cold)." The staff member did not take any action to ensure the person was kept warm.

We saw that other people's needs were not readily met and we could smell that people required help with their personal care. On both days of our inspection there were unpleasant odours in various parts of the home. On the second day we found two pairs of urine soaked slippers drying on top of a bathroom radiator. The odour caused was unpleasant and showed little respect for people or their home.

Staff were not always discreet when supporting people with their personal care needs. We clearly heard a staff member talking with a person about their constipation in the lounge area where other people were present.

We found some people were wearing ill-fitting clothing and footwear that compromised both their dignity and safety. We saw that the hems had come down on one person's trousers and that their trousers were falling down. When we spoke with one staff member we were told that the person would not tolerate wearing a belt. We saw the person walking up the corridor holding on to their trousers as they walked. We spoke to a different staff member who helped the person to put a belt on. The person was seen to wear the belt for the rest of that day and for the second day of our visit. We saw that a five people were wearing ill-fitting footwear that had become worn and posed a trip hazard when they were walking. On the second day the registered manager told us they had been in contact with people's relatives and new clothing and footwear had been purchased.

On West View unit at lunchtime we saw one person had a nose bleed. There was blood on their hands, over their face and had dripped onto their clothes. The person was trying to wipe it away and became anxious. We saw three members of staff in the same room talking amongst themselves who did not help the person until we asked them to.

Staff did not always offer people choice. At lunchtimes we saw that some staff placed tabards on people without explaining or giving them choice about wearing one. We also observed that staff did not offer people choice about whether they wanted music or the television put on or off. For example, when two people became anxious with each other the staff member supporting them turned the television off without consulting the other people who were watching it.

Staff did not show regard for people when they became upset and therefore they became more distressed. We observed how staff interacted with people during lunchtime on Castle View unit. There were two staff on the unit. One staff member was supporting a person to eat their lunch sat in the armchair. They told us that they could not leave this person because they would not take any further food if they had a break in their support. The second member of staff was assisting another person to eat at the table. The other people sat at the tables became restless and started banging on the table asking where their food was. The second staff member took the meal away from the person they were supporting and told them they would have to wait for the rest whilst they went to get the other people's meals from the kitchen. The person began to raise their voice and swear. The staff member proceeded to leave the room and this person started to swear at the person sitting next to them. This resulted in a five minute exchange of swear words between the two people before the second person got up and walked out of the room. They said they 'were going and did not want to come back.'

When the member of staff returned with the lunch trolley 13 minutes later they found the person who had left the table standing in the hallway. They were upset and told the staff member they did not want to sit by the person who had sworn at them. Despite this the staff member sat this person in the same place and within three minutes the two people were arguing again. Staff did not intervene and the person removed themselves from the situation again. Following their departure a staff member seated another person at the table and within minutes they were crying and asking for their spouse and asking to go home because they had been shouted at. At this point staff did intervene and direct their attention to the person who had had their meal taken away in the first place. This person had their meal returned to them and was able to finish eating it. When we spoke with registered manager they told us staff should have used the call bell to request assistance from other staff or management. They went on to explain that using the call bell was the only means for staff to call for the assistance without them leaving the unit.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they got to know people by reading their care plans and by talking with them and their relatives. One staff member said, "You've got to get to know the person. I like to interact with people." They went on to say, "I want to get it right for them." We saw that people were comfortable in the company of staff and that staff chatted with people in a friendly manner when supporting them with tasks. A relative we spoke with found staff friendly and welcoming when they visited. Staff told us they gave people choices such as, what they would like to wear and what they would like to eat and drink. Where people had difficulty choosing they said they would show them choices such as different items of clothing. Likewise with meal options there were pictorial menus available and we saw staff prompted people to use these to choose their meals.

People were supported to keep in contact with friends and relatives who were important to them. One person told us they went to visit their spouse each day and staff supported them to do so. Another person told us they were going out to the hairdressers and then going for a meal with their spouse. A Staff member told us they supported one person to telephone their spouse each day.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support that was responsive to their changing needs. People were assessed prior to moving into the home and senior care staff were responsible for keeping their care plans and risk assessments up to date. The registered manager told us care plans were reviewed on a monthly basis or as people's needs necessitated. However, we found that care plans and risk assessments did not always reflect the support people required or received. For example, one person was locked in their bedroom at night and this was not reflected in their care plan or risk assessments. Another person had very swollen legs and staff had not identified the support they required to help reduce the swelling and the risk of skin breakdown. The registered manager took immediate action to review the care records we had identified. They also arranged care planning training for senior staff for the day after our inspection.

Staff told us they were informed about any changes in people's needs during staff handover. One staff member told us when they had been off on leave they received a more detailed handover to ensure they were up to date. Staff we spoke with were able to demonstrate they knew people well and were able to tell us about their interests and about their past lives. For example, one person used to play football and the staff member prompted the person's memory as we were talking with them. They said when there was football on they would put the television on their bedroom for them to watch it. Another person liked to play chess and a staff member told us they went to chess club each week.

We looked at how people spent their time. Some people told us they chose to remain in their room as they preferred their own company. One person told us, "Nothing much happens here really." Apart from a church service held in the day care centre on the first day we found staff had limited time to engage with people other than when they were assisting them with tasks. This meant some people spent a lot of time doing nothing or sleeping in their chairs. The registered manager told us they employed two activity workers who each worked two hours per week who were able to provide one to one or group support. The registered manager told us that care staff were expected to engage and support people to do things they enjoyed doing on a daily basis. They told us and we saw that they also arranged for entertainers to visit the home on a weekly basis.

The registered manager told us they encouraged feedback from people and their relatives. An annual survey had just been completed and the completed forms had been sent to head office for analysing. Head office would subsequently send the outcomes together with an action plan to address any areas for improvement. The registered manager told us and we saw they held regular meetings with people that lived at the home which their relatives were able to attend. As a result of feedback from people they had made improvement to the service. For example, a cooked breakfast was previously only served two days per week whereas now people could choose to have cook breakfast every day if they wished.

People felt able to approach staff or management if they had any concerns. Staff we spoke with demonstrated they would take appropriate action should people or their relative's raise concerns. The provider had a clear complaints process in place which was available in other formats if required. We saw that complaints received had been appropriately investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post since May 2016. They told us their vision for the service was to provide person centred care to meet people's needs and to achieve a good Care Quality Commission inspection rating. They explained that the previous manager had left in April 2016. One of the assistant manager posts and the administration worker post had been vacant until September 2016. They felt that these staff vacancies had impacted on their capacity to identify and make required improvements to the service.

At our last inspection the provider needed to make improvements to how they monitored the quality and safety of the service. They also needed to improve their deployment of staff and to ensure staff received adequate training to enable them to meet the needs of people living at the home. At this inspection we found that improvements had not been made and further areas for improvement were identified.

There was a lack of effective leadership in the home that failed to give staff direction to recognise the needs of the people using the service. For example we found staff did not respond to people's needs when they were distressed, staff had told us they wanted more training to help them understand challenging behaviour so that people would not be so upset. There was also a lack of effective monitoring systems to identify any areas for improvement and as a result people's health and wellbeing was compromised. For example, the registered manager had not identified that one person had not been involved in the decision not to be resuscitated even though they had capacity to so. This meant that the person's was at risk of not having their wishes been respected. The registered manager told us they completed routine checks on Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) where they checked they were in date and that they had the original copy. They arranged for the person's DNACPR to be reviewed by the GP. They also agreed to review their systems to ensure people were involved in decisions about their care and treatment.

The registered manager told us that they or the duty manager completed walk rounds of the home three to four times a day. This allowed them to monitor staff practice and provide support where necessary. Despite the checks in place we found that the registered manager was not aware of the staff's day to day practice. They had failed to identify the deficits in staff knowledge and the poor practice that we had highlighted during our inspection. This included staff's lack of understanding of how to manage people's behaviours, promote effective health care and how to protect people's dignity. They were also not aware of potentially unsafe practices such as poor moving and handling techniques or restrictive practices such as staff locking one person in their bedroom at night.

We found that there was a lack of transparency and a complacent working culture at the home. Staff were not always clear on their roles and responsibilities and had failed to deliver effective care to people. Whilst the registered manager took action to address some of the shortfalls we had identified we considered this as reactive to our observations. We therefore were not confident that the concerns we had raised would have been identified and acted upon without our intervention.

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

2014

The registered manager told us they completed a range of audits such as, medicines, health and safety audits and care plan audits. They explained they had fallen behind with their schedule due to the lack of administrative support but were now able to resume normal practice. The provider also completed compliance audits on a monthly basis. Outcomes of these audits were developed into an action plan which was reviewed at the subsequent compliance visit to ensure progress. The provider held health and safety meetings every two months where they reviewed accidents and incidents that had occurred at the provider's homes, shared their learning and best practice. For example, they told and showed us a new falls assessment process was being introduced from the outcomes of these meetings.

Staff we spoke with said the registered manager was very visible within the home and would help out with care tasks if needed. One staff member said, "They are firm but fair." Another staff member told us, "Their focus is on this place as it should be as registered manager." There was a clear management structure in place and staff could contact a senior member of staff outside office hours if they required guidance or support. As well as being supported by the staff team, the registered manager could contact the provider or another registered manager for support. The provider also held an operational managers group each month which provided managers with the opportunity to gain advice and support.

The provider had agreed resource for the refurbishment of the home and the work had commenced on the second day of our visit. The registered manager told us the provider had employed "dementia designers" who had specialised knowledge of dementia friendly environments. They were confident the refurbishment was sensitive to the requirements of people living with dementia. We saw that there was information about the refurbishment available for people to refer to on each unit. The registered manager told us they held a refurbishment meeting at the home and sent letters to people's relatives to ensure everyone was involved in the discussions. They intended and to hold monthly meetings to people up to date with the progress of the refurbishment.

The registered manager told us and we saw that they maintained links with the local community. For example, students from the local college completed work experience at the home. The local church held services at the home.

The provider had submitted statutory notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events and changes at the service without delay. This allows us to monitor any trends within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people's dignity was protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always ensured that decisions made on behalf of people were in made their best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to ensure that the service was meeting the needs of the people, keeping them safe and managing the risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that enough suitably trained staff were deployed to meet people's needs.