HC-One Limited

County Homes

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 1, 2 and 4 November 2016. County Homes is a large care home set in its own grounds in Woodchurch, Wirral. The home is registered to provide personal care and nursing care for up to 90 people. The home primarily caters for adults who live with dementia.

The home accommodates six individual units over two floors. Some units are mixed, other units are male or female units only. Each person in the unit has their own bedroom and some of the bedrooms have en-suite facilities. A passenger lift enables access to all floors for people with mobility problems. In each unit there is a communal lounge and dining room for people to use. There is also a pleasant garden for people to enjoy and a small car park.

There was a registered manager in post. 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.'

During this visit, we identified concerns with the safety and quality of the service. We found breaches in relation to Regulations 9, 12, 18 and 17 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 this report.

We looked at the care files belonging to seven people. We found some people's needs and risks were not properly assessed and some management plans did not give staff sufficient guidance on how to meet people's needs and keep them safe.

Some of the people who lived at the home displayed challenging behaviours. We found that people's support in relation to this was inadequate. Staff lacked sufficient information on the potential causes of the people's distress and how to support people to communicate their needs in a more constructive way. The support provided was not person centred and in some instances not an appropriate way to meet people's needs. Dementia care overall was poor and staff had limited guidance on to communicate with and provide emotional support to people who lived with dementia.

Some of the moving and handling techniques used by staff at the home to support people's mobility was unsafe. People's nutritional needs were assessed with advice sought from the dietician when required. People had enough to eat and drink but some people who required assistance to eat their meals were not supported in a safe way. This placed people at risk of harm. People we spoke with were generally pleased with the quality and choice of food that they had at the home.

Some of the people we spoke with said there was not enough to do. We saw that some activities were available upstairs in the home's activity room but no thought had been given to those people who due to

their dementia were unable to participate in these activities. We saw some people had no access to any meaningful or suitable activities and spent most of the day sat in a chair or wandering around the unit. This did not promote their emotional well-being or quality of life. People's care files contained information about people's previous hobbies and interests but there was no evidence that this information had been used to plan activities designed to occupy and interest people.

Of the seven people's files we looked at, six had personal emergency evacuation plans (PEEPs)in place that contained personal information about their needs in an emergency situation. One person did not have a PEEP in place and the PEEPs we looked at did not contain adequate information about people's support needs. This information was also displayed in the entrance area of the home which did not respect people's confidentiality.

People's capacity was assessed in accordance with the Mental Capacity Act but capacity assessments lacked sufficient detail of how the capacity assessment was undertaken and the person's participation. Some people who were unable to keep themselves safe outside of the home had deprivations of liberty safeguards in place to ensure they were cared for appropriately.

We saw that the manager had responded to people's complaints or concerns but had not always kept appropriate records in relation to these. The provider's complaints policy also lacked important information in relation to who people could complain to.
Staff recruitment, training and support was satisfactory but the number of staff on duty was found to be insufficient. This placed people at risk of avoidable harm.

During our visit, we found the culture of the home to be warm, open and transparent. People who lived at the home and the relatives we spoke with during our visit told us staff were kind and caring. We observed interactions between staff and people who lived at the home that were pleasant, kind and compassionate. It was clear that people felt comfortable with the staff that supported them. Staff we spoke with spoke fondly of the people they cared for.

We saw that the home had been refurbished throughout and was tastefully decorated. There was also a new café area at the entrance of the home. We looked at the arrangements in place to ensure the premises was safe. We saw that improvements were required to the home's emergency lighting and fire safety provisions. This had not been done. This meant the provider failed to take appropriate action to protect people from risk in the event of an emergency such as a fire. The manager contacted the provider the day of our visit to organise the required works.

Medicines were managed safely but staff needed appropriate guidance for when to administer people's 'as and when' required medication so that people received these medicines as needed. People had prompt access to their GP when they became unwell and other specialist health and social care professionals in support of their health and well-being. We saw that where professional advice had been given, it was properly documented and followed.

Safeguarding incidents were recorded, appropriately investigated and reported. Staff we spoke with knew about types of abuse and the action to take if they suspected abuse had occurred.

The service was not consistently well–led. Systems in place to monitor and manage risk to people's health, safety and welfare were in place but were ineffective. They did not pick up the concerns we identified during our visit. We had concerns about risk management, poor staff practices in the delivery of care, insufficient staffing levels, the lack of good person centred care, the access to meaningful activities for some people and

inadequate support for people's emotional and behavioural needs as part of their dementia care.

We discussed our concerns with the manager at the end of the visit. They were receptive to our feedback and demonstrated a positive commitment to improving the service for the people who lived there.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's needs were not always properly assessed and managed in a person centred way.

Support for people's emotional needs and challenging behaviours was poor and did not ensure their needs were met

Some staff practices were unsafe. For example moving and handling and the way in which some staff supported people to eat.

Staff recruitment was satisfactory but staff levels were insufficient to minimise risks to people's safety and care.

Some improvements to the home's emergency lighting and fire safety provisions had not been made.

Is the service effective?

Requires Improvement

The service was not always effective

People's capacity was assessed but their assessment lacked sufficient evidence of their involvement or any best interest process. This required improvement.

People who were unable to keep themselves safe had deprivation of liberty safeguards in place to protect them from harm.

Staff were trained to meet people's needs and supported appropriately in the workplace appropriately.

People nutritional needs were assessed with professional advice sought when necessary. People got enough to eat and drink and their nutritional needs were monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

The majority of people and relatives we spoke with said staff were kind and caring.

The atmosphere at the home was warm, open and homely. People were relaxed and comfortable in the company of staff.

We saw that interactions between staff and people who lived at the home were unrushed, friendly and compassionate.

People had access to information about the home and the support that was provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were insufficient activities to meet the needs, interests and preferences of all of the people who lived at the home. Some people had access to no meaningful activities.

People's care plans contained little information on how to support and promote their emotional and mental well- being in a person centred way.

People's health was monitored and staff took appropriate action when people became unwell.

People had prompt access to their GP and other health and social care professionals as and when required.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager completed a range of audits as directed by the provider. Where actions had been identified in these audits, the manager had acted upon these promptly.

The provider's audit framework failed to identify and address the concerns which we found during our inspection for example safe and inappropriate care, poor staffing levels, premises improvements and poor dementia care.

People's opinions on the quality and safety of the service provided. Where improvements were needed there was no evidence appropriate action had been taken.

County Homes

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 1, 2 and 4 November 2016. The first day of the inspection was unannounced. The inspection was carried out by one adult social inspector and an Expert by Experience who assisted on the second day of the inspection. An expert by experience is person who has personal experience of using or caring for someone who uses this type of service. During the inspection, the experts by experience spoke to people who lived at the home and their relatives or visitors to gain people's views on the quality of the service provided.

Prior to our visit, we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority for their feedback on the service.

At this inspection we spoke with six people who lived at the home and three relatives. We also observed the provision of day to day care. We spoke with the registered manager, two unit managers, HC-one's turnaround manager, the assistant operations manager, two care staff and a visiting GP. We looked at a variety of records including seven care records, recruitment records for five staff, staff training records, medication administration records and other documentation relating to the management of the service.

We looked at the communal areas that people shared in the home, did a tour of the home and visited a sample of people's bedrooms.

Inadequate

Is the service safe?

Our findings

Some of the people who lived at the home lived with mental health conditions that meant they found it difficult to talk to us during our visit. We chatted to six people who lived at the home and asked three relatives about the care their loved one received.

People we spoke with told us they felt safe with the staff who looked after them. People's comments included "No-one says anything in a nasty way. The staff are always nice to us"; "There are no problems" and "I feel reasonably safe providing I can go to my room at night". Relatives we spoke with also felt people were safe with staff at the home.

We looked at seven people's care files. In all of the files we looked at, risks in relation to people's care were assessed for example, risks in relation to skin integrity, mobility, nutrition, moving and handling, falls and challenging behaviour were all in place. Some of the risk assessments in relation to people's needs and care however had not been totalled so that the level of risk was clearly identified. Without this detail it was difficult to determine how staff were able to plan safe and appropriate support. Some of the risk assessments and management plans also lacked sufficient detail for staff to follow to ensure safe and appropriate care was provided. From our observations we found that risks in relation to some people's care were not always managed safely.

For example, one person experienced challenging behaviours due to living with dementia. The person had a behavioural risk assessment but it failed to describe any potential triggers that may cause the person distress so that preventative action could be taken. Risk management advice advised staff to use diversional techniques to support the person's behaviour but gave no guidance on the type of diversional techniques to use or what techniques had previously proven effective in minimising the person's upset. We asked the manager if any behavioural monitoring had taken place to enable staff to gain an understanding of any potential causes of this person's behaviour or identify strategies for support that would help minimise their agitation and distress. The manager acknowledged no monitoring had been undertaken.

We observed this person's support during our visit. This person was active throughout the day and was followed at all times by one member of staff up and down the corridor. Staff members constantly re-directed the person each time they stopped to interact with another person or member of staff. The person was prevented from making any meaningful contact with others and the staff members in question failed to engage in any meaningful way with the person they were supporting.

We observed the serving of lunch to one person who required support to eat. The support provided was inappropriate and unsafe. The person was asleep at lunchtime. We observed a staff member support this person to eat whilst they were still in a sleep induced state. The person was slouched in their chair, not in an upright position and the spoon used to enable the person to eat their meal was a dessert spoon. The staff member filled the spoon with large mouthfuls of food and kept having to wake the person up between mouthfuls. The person ended up with food all around their mouth as too much food was on the spoon and the person was only half awake when eating. This was not a very dignified or safe way to provide nutritional

support.

We checked the person's care file and found that the support we had observed placed the person at high risk of choking and aspiration pneumonia. We saw that the person's risk assessment stated that the person was unable to clear their throat, was confused and had difficulty swallowing. This meant there was a risk that the person did not know that food was being placed in their mouth to swallow and that they were physical unable to swallow the large mouthfuls of food they were being given to eat. These risks were further increased by the fact the person was half asleep.

We found that the support provided by staff in respect of people's mobility was not always safe. We observed four incidences during our visit where inappropriate moving and handling techniques were used to support people with mobility issues. These techniques placed people at significant risk of an accident or injury. We spoke to the manager about this. They acknowledged that the techniques we had observed were inappropriate. We also found that staff did not always follow moving and handling guidance to keep people safe or know which hoist to use with people who were unable to weight bear.

Five of the six care files we looked at contained a personal emergency evacuation plans (PEEPS) for each person. One person did not have a PEEP in place. PEEPs provide emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. This information assists emergency service personnel to quickly identify those most at risk and the best method by which to secure their safe evacuation.

We found whilst people's physical needs were identified in their PEEPS, their mental health needs for example, confusion, challenging behaviour which may impact on their ability to escape unassisted were not described. This meant emergency staff lacked sufficient information about people's abilities to ensure they were evacuated safely. In addition, we saw that a copy of people's confidential PEEP information was stored in the entrance area of the home for anyone who visited the home to see. This did not respect people's right to confidentiality.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed

The home employed a maintenance officer who undertook routine maintenance and regular checks of the home's fire extinguishers, fire alarm, bed rails, water temperature and general environment. The home itself had recently undergone a major refurbishment with new flooring and furniture installed and a new café in the entrance area of the home.

Parts of the home during our visit were malodorous. One relative we spoke with told us "The carpet by the door as you come into the unit smells of urine. It is an overpowering and very unpleasant smell. Five days out of seven it is like that".

We checked the premises in which people lived, was safe and suitable for use. The manager told us the provider had an estates department (off site) that looked after all major premises requirements including the annual testing of the home's equipment in accordance with legal requirements. We looked at the provider's records in relation to this.

We saw that the provider's gas, electrical and fire installations were regularly serviced and inspected by qualified persons competent to do so. The home's emergency lighting had been inspected in January 2015

and we saw that ten emergency lights had failed the inspection. This meant that in the event of an emergency evacuation these lights would not work properly to guide people to a safe exit. From the records we looked at, there was no evidence that any action had been taken.
A fire risk assessment had been completed by a certified fire assessment officer in July 2016. A number of fire safety actions had been identified by the fire officer in order to ensure people were protected from potential harm in the event of a fire. There was no evidence that these actions had been undertaken. We spoke to the manager about this. They contacted the provider's estates department who confirmed that no action had been taken. This meant that no appropriate action had been taken to ensure risks to people's health, safety and welfare were mitigated against in order to protect them from harm.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the premises were safe for their intended purpose.

We saw that the kitchen was awarded a five star food hygiene rating from Environmental Health in September 2015. This meant food hygiene standards were rated as "very good".

People we spoke to during our visit told us they thought staffing levels were for the majority of the time satisfactory. Relatives we spoke with however had a different view.

One relative said "The staff are overworked". A second relative said "The staff work long hours. They are extremely lucky if they get a break. They keep going". Another relative told us "There are not many staff on and sometimes I have been in the lounge when there have been no staff there as they have been called away. There was no staff around for ten minutes yesterday when I was sitting in the lounge. The girls work so hard. I feel really sorry for some staff. There are not enough staff".

During our visit we found staffing levels to be insufficient. People were sat for long periods during the day without any meaningful interaction from staff. Some lounge areas of the home were sometimes left without a visible staff presence to ensure people's safety was maintained. For example, on entering the communal lounge on the Chester Unit on the first floor we found a person asleep on the couch. This person's lower body was hanging off the couch and the person was at significant risk of a fall. There were no staff members in the vicinity to assist this person to safety and we had to ring the emergency buzzer for staff assistance.

On the second day of our visit, we visited the Lancaster Unit on the first floor. We found a person asleep in an undignified state on their bed. Their bedroom door was wide open and a plate of half eaten food was by their feet on the bed. We went to find a staff member and saw that there was only one staff member in the communal lounge. They told us they were unable to leave the lounge to assist as they had to stay with one particular person at all times due to their tendency to wander. This meant that should this person move out of the lounge area, the other people in the lounge would have no access to staff assistance. It also meant the staff member was unable to help the person we had found.

These incidences were a breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the number of staff deployed was insufficient to maintain people's safety in some areas of the home.

We did a stock check of a sample of the medication in the home and found that the amount of medication in the trolley corresponded with what had been administered. Records showed that senior care staff were trained to administer medication. We observed a medication round and saw that medication was given in an appropriate and pleasant way. A relative we spoke with said "The staff have sorted out their (the

person's) tablets and always keep me informed of what they are on. They are good at liaising with the doctors".

We saw that 'as and when' (PRN) required medications such as painkillers and prescribed creams were in use at the home. There were PRN plans in place. PRN plans are designed to advise staff, how, when and why to administer as and when required medications. We found people's PRN plans did not always provide sufficient information to enable staff to assess when the administration of an 'as and when' required medication was appropriate.

We looked at five staff files. All the files we looked at showed that the necessary checks to ensure that staff employed were of good character, and suitable to work with vulnerable adults had been undertaken.

We spoke to two staff members about protecting vulnerable people from potential abuse (safeguarding). Both staff members were able to tell us about different types of abuse and what action they should take if they suspect abuse had occurred. Staff training records showed that the majority of staff members had received safeguarding on a regular basis. We looked at the provider's safeguarding records. We saw that these incidents had been investigated and reported in accordance with local safeguarding procedures.

Requires Improvement

Is the service effective?

Our findings

People we spoke with were generally satisfied with their care. People's comments included "Everybody is nice to me. I have good food. We can go out whenever we like. It's a nice place to be. The staff are very kind and very nice; "It's quite a good place"; "There are little things I am not happy with, but some things I bring upon myself" and "As far as I live here it suits me".

The majority of the relatives we spoke with spoke positively about the home and felt the person was happy at the home. One relative said "They (the person) is happy on the whole" another relative said "They (the person) were very agitated when they first came. The staff have done a very good job of helping them settle in. I am very happy they (the person) are in here".

People we spoke with were generally happy with the food that they received at the home. People's comments included "The food is always nice"; The food is alright. There is not much I dislike"; "On the whole it's pretty good" and "The meals are what you would expect. They are well cooked. There is a variety of different things on different days. The food is not pushed at you. If there is a meal I don't like, there is always something else. There is a choice. There is also a choice of drinks. My favourite drink is tea".

One relative we spoke with said "The menus are lovely. The food is beautiful. It is a balanced diet. I eat with them (the person) but I pay for my meal. They have chicken, pork, lasagne and a choice of vegetables. The menus is displayed in the lounge. They (the person) are asked on a daily basis what they want. They can sleep in and have a late breakfast".

Another relative told us they felt the person got enough to eat and drink but that "The menu is not always as printed" and a third relative said "The menus here are instructed by head office. They are catering for eighty people. It is not easy. The quality of food is not up to my standard. They (the person) can get a drink any time of the day. The girls are always going round with hot or cold drinks.

We observed lunch and saw that people's meals were served pleasantly and promptly by staff and that people were given enough to eat and drink. Dining room tables were set nicely, with tablecloth, cotton napkins and a decorative centre piece. The atmosphere at lunch was relaxed and homely which made for a positive dining experience. Snacks and drinks were available and offered to people who lived at the home at frequent intervals throughout the day.

We saw that there was a written menu in each unit for people who lived at the home to refer to, There was however a lack of visual prompts such as picture menus to make choosing a meal easier for people who lived with dementia.

In all of the files we looked at, people's nutritional needs had been assessed and guidance given to staff on how to support people's dietary intake. People's weights were regularly monitored to ensure that their nutritional health was maintained. People at risk of malnutrition or those with special dietary needs were referred to the dietetic service in accordance with the risk assessment and any professional advice given was

documented appropriately in the person's care file.

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.

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. Some people at the home had deprivation of liberty safeguards in place to protect them from harm. We saw that a mental capacity assessment had been completed prior to the deprivation of liberty safeguard application being submitted to, and approved by the Local Authority. We also saw that people had capacity assessments in place where specific decisions about their care needed to be made. All of the capacity assessments looked at, followed the two stage test of capacity recommended by the MCA but lacked sufficient detail of the person's involvement or evidence that best interest decision making process had been undertaken. There was also no explanation as to what alternative least restrictive options had been explored before a decision to deprive a person of their liberty had been taken. This aspect of MCA and its implementation required improvement.

Throughout the inspection we heard staff seeking verbal consent from people prior to providing support. This ensured that people gave their consent to the care being offered before it was provided. Staff we spoke with demonstrated an understanding of mental capacity and how to promote people's choice in their day to day lives.

There were six individual units within the home, some were male or female only, others were mixed. Each unit was tastefully decorated with a communal lounge for people to sit in and watch television or chat. Some lounges were more homely than others. There were also seating areas for people to rest in each corridor which provided people with a quiet area in which to sit and relax. People's bedrooms had their name on the door at eye level which made it easier for people to see and recognise. There was also some signage in and around the building to help people recognise the doors to the bathroom or toilet which helped people maintain their independence. The addition of contrasting or coloured toilet seats and taps in these areas may help people living with dementia to recognise what these items are for. People living with dementia must be able to see what they need to use, because they may not be able to remember easily.

We looked at staff training records and saw that staff employed had received training to meet the needs of the people they cared for. Training for example was provided on moving and handling; safeguarding, fire safety, first aid, food hygiene and nutrition, infection control, falls prevention and dementia care. Staff members also had access to training specifically in person centred care with courses such as 'kindness in care' and 'creating therapeutic relationships'.

We asked two staff about the support they received from their line manager. Both staff told us they felt supported in their role and well trained. They said that they had regular supervision with their line manager to discuss their day to day role and an annual appraisal of their skills and abilities. The manager provided evidence to confirm this.

One staff member told us "There is always someone on hand to talk to if you need advice".

Requires Improvement

Is the service caring?

Our findings

The majority of people we spoke with said the staff were kind and caring. One person said some staff were not as caring as others. One person said "I have a good laugh with the staff. They are young, not fuddy duddy. They are more in keeping, more up to date. If I ask for a hug, I get a hug from staff. They have a lovely manner and I have lovely conversations. Whereas another person told us "The staff are pretty good. They are friendly enough but some get a bit bossy. Most of them are kind and caring. One or two are a bit hard".

Relatives we spoke with spoke highly of the staff on duty. Their comments included "There are no problems with staff"; "The nurse who runs the unit is very caring" and "I like the atmosphere. It is very good, very tranquil and very friendly. Everyone says hello".

During our visit, we found the atmosphere and culture of the home to be open, transparent and warm. People were seemed relaxed and comfortable in the company of staff. People looked smartly dressed and care for. We observed positive interactions between people who lived at the home and staff when people needed support.

Staff were observed to be kind, caring and compassionate in their approach. It was clear that staff had positive relationships with the people they cared for. The manager and staff we spoke with during our visit had an understanding of people's needs and spoke about people affectionately. It was obvious that staff cared for the people they looked after.

We saw that people who lived at the home and their relatives had participated in a satisfaction survey undertaken by the provider in May 2016. 88% of people who lived at the home and 92% of relatives surveyed, felt staff were caring.

When we looked at people's care files, we found that they lacked information about people's preferences for how they would like to be cared for at the end of their life. Some people had do not resuscitate decisions in place but people's wishes in relation to their end of life care had not been documented for staff to follow. This aspect of care planning required improvement to ensure people's needs and wishes were met and respected.

We saw that resident meetings took place every three months with the people who lived at the home to share information about the place that they lived. Records showed that only a small number of people attended these meetings but that they were asked their opinions about things that may have been important to them. For example, people were asked for feedback on the general environment, their care and activities. Some consideration however needed to be given to how people who were unable to communicate verbally may be able to participate in these meetings and consideration given to other methods of sharing information and gaining people's opinions about the home that may be more suitable for people living with advanced dementia.

A service user guide was available to people who lived at the home. The service user guide gave people and their relatives' written information about the home, the philosophy of care, the facilities available and the care provided at the home. The guide was written in a good sized font which made it easier for people living with dementia to read.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with had mixed opinions about whether there were sufficient activities to become involved with at the home. People's comments included:

"I like the company. I'm not lonely. There is always someone to natter to, but I don't go out enough. Theatre is my favourite. I would like to go to the theatre".

"It's just like I would have at home. There is no particular sport catered for each week, but there is always something you can do. I don't do much now. My main hobby was walking. I can sit outside and think. I can sit outside and draw".

"There is nothing to do here. All I do is walk about. I would like to go on a short holiday. They could take you out a bit more often as I'm not taken out much".

"I've been here two years. I always said that I would like to go out a bit more, such as in a wheelchair but they have only got four wheelchairs in this ward. If we go out we go out on a mini-bus. The lady who takes us if very nice. We have been to Llangollen canal, the zoo and the Iron Bridge".

During our visit, we saw that some people attended the activities room on the first floor and participated in a pub lunch. There was a large arts and crafts room for people to enjoy and a tea room for people to take their visitors. Two activities co-ordinators were employed at the home but during our visit, they remained mainly in the activities room upstairs. We found that some people sat for the majority of the day in the communal lounge with just the TV or the radio on. Due to their level of dementia, they may people not have been able to participate in the activities provided due to this. These people were observed to simply sit in a chair in the lounge or wander up and down the corridor for most of the day. We did not see any activities offered to these people during the three days we visited.

We saw that people's care files contained a personal life story about them. Personal life histories enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. We saw little evidence however that this information had been incorporated into the person's activity plan so that person centred activities could be provided.

For example, we saw that one person had led an active life prior to coming to live at the home. They enjoyed walking, gardening and being out in the sun. During our visit, we observed that this person wandered for most of the day and was constantly being monitored and re-directed by staff. It was a dry, pleasant day during our visit and the sun was shining. Despite this, the person was not supported to enjoy the garden outside or go for a walk.

People's activity plans simply stated the same activities for each person. This was 1:1 time with staff, visits from family and representatives from the church. We did not see any evidence of any meaningful 1:1 time with staff. All of the staff on duty were busy with other tasks and no staff had free time to spend specifically

with one person to engage them in an activity. Some people had visitors but no representatives from the church attended whilst we were at the home.

We looked at the care files belonging to seven people. We saw that people's needs had been assessed before or on admission to the home. All of the people whose care file we looked at lived with dementia. Staff had some information on how the person's condition impacted on their day to day life but little guidance on how to support the person's mental health and emotional well-being.

For example, staff had some details of people's challenging behaviours but little guidance on how to support the person in a person centred way to minimise their distress. There were no communication aids such as picture charts to enable people who may find communicating their need or emotions verbally difficult in use. Behavioural monitoring tools were not observed to be in use to monitor people's emotional health in order to help staff gain a picture of any patterns or causes of the person's distress so that strategies for minimising the person's exposure to these could be identified.

Information in people's personal history had also not been used in any meaningful way to help develop techniques for diffusing episodes of distress or challenging behaviour. No consideration had been given to whether episodes of people's challenging behaviours were brought on by boredom, long periods of inactivity and a lack of stimulation which may have been linked to the lack of meaningful activities for those people at the home who lived with advanced dementia.

These issues demonstrated that the planning and delivery of dementia care at the home required improvement so that positive outcomes for people could be promoted in terms of their quality of life.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people received person centred care that met their needs and preferences.

Care plans and risk assessments were regularly reviewed but people's review notes were limited and some people's daily notes were difficult to read due to the quality of the handwriting.

We saw in people's care files that people had prompt access to their GP when they became unwell. We observed two incidences of this in action during our visit wherein staff quickly spotted the signs of ill-health in two people at the home and responded immediately by calling the person's GP to arrange a home visit. We were at the home when the GP visited.

The GP told us that staff at the home did "A wonderful job" that they were "Very passionate" about the care they provided and "Always followed instructions". They said that they had a good relationship with staff at the home and that staff would "Say if a person needed something".

There was also clear evidence in care files of the involvement of other healthcare professionals in people's care for example mental health teams, district nurse, dieticians and opticians. There was evidence that people's physical health was regularly monitored. People's weights were taken regularly and people who were at risk of malnutrition had their dietary intake monitored to ensure they received sufficient nutrition. Records showed that people who required repositioning to prevent a pressure sore received this support and people had access to occupational health and the falls prevention team when their mobility declined. This demonstrated that people received the support they needed in relation to their physical health and well-being. We saw that where professional advice had been given, people's care plans had been updated accordingly and the advice followed in the day to day delivery of care. This was good practice and ensured

each staff member was fully aware of any new care requirements the person needed.

The information provided to people in relation to how to make a complaint required improvement. We saw the provider's complaints procedure displayed on the communal noticeboard. We found that the contact details for ''manager to whom people were advised to direct their complaint and the contact details for the Local Authority Complaints Department were not detailed on the procedure displayed.

The complaints information in the provider's service user guide was confusing. It did not clearly explain how people could make a complaint for example verbal or in writing and the order in which information was set out was difficult to understand. For example, the policy advised people about how their complaint would be acknowledged and responded to before advising people who they should talk to about their concerns.

We asked to see records of any complaints the manager or provider had received. We looked at four complaints. We saw that the manager had a complaint log that held brief details of the outcome of the complaint. From this log we could see that the manager had documented what action they had taken to investigate and respond to the complaint. We found however that although the complaint was clearly logged by the manager, there was no formal evidence the manager had formally responded to two out of the four complaints we looked at on file. This aspect of complaint recording required improvement.

Requires Improvement

Is the service well-led?

Our findings

We looked at the arrangements in place to assess, monitor and mitigate risk to people's health, safety and welfare. We found some of the provider's arrangements to be ineffective.

We saw that the manager and staff undertook a range of regular audits to monitor the quality and safety of the service provided at the home. This included an audit of people's care and risk assessments, health and safety, the environment, infection control, accident and incident and medication. We saw that where actions for improvement had been documented the majority of these had been addressed. We saw that one of the provider's quality assurance managers visited the home monthly to carry out an audit of the quality and safety of the service provided and that staff meetings were held on a regular basis to discuss any concerns or improvements the service needed. We found however that the quality assurance framework implemented by the provider at the home was not effective in ensuring people always received safe and appropriate care.

For example, we looked at the last three audits completed by the provider's quality assurance manager in July, August and September 2016. We saw that these audits had identified that only a third of the staff team had up to date moving and handling training. The quality assurance manager specified this as a 'serious risk to address'. In August only 34% of staff had completed moving and handling training. In September this had only rose by 3% to 37%. This did not demonstrate that the manager had addressed this with the staff team in order to minimise the serious risk identified by the provider's quality assurance manager. During our visit, we observed several incidences were inappropriate and unsafe moving and handling techniques were used by staff which placed people at risk of avoidable harm.

We found that none of the audits completed by the manager were effective in identifying the areas of concern we had found during our visit. Systems in place to ensure staffing levels were sufficient were not robust as staffing levels observed during our visit in some of the units were insufficient and people were placed at risk. Systems in place to ensure improvements to the home's emergency lighting and fire safety arrangements were made failed to ensure the required works were undertaken.
The lack of adequate risk management and care plan information in some areas of people's care had not been picked up. Concerns with the way some people were supported to eat their meals had not be identified and none of the audits picked up that some people lacked access to any meaningful activities to promote their quality of life or that the provision of dementia care overall required improvement.

There were no adequate systems in place to ensure that strategies to support some people's challenging behaviours were person centred or that people had access to alternative methods of communication so that they were able to convey their needs and wishes to staff.

We saw that a satisfaction questionnaire had been sent out to people who lived at the home, their relatives and any visitors to the home in May 2016 to enable feedback on the service to be gained. People were asked for their feedback on a number of areas in relation to the home for example, staff attitudes, staff responsiveness, standards of meals, the general environment and complaints.

We saw that the feedback from people and their relatives had been analysed to show the home's performance in each area. We saw that the home had some areas where improvements were required based on people's feedback. For instance, 50% of those who responded did not feel their views were always respected; 43% were not aware of how to make a complaint and 38% felt that staff were not always responsive. There was no evidence that any action had been taken to address these areas. This meant that although feedback had been sought on the quality and safety of the service provided, it had not always been acted upon to ensure improvements were made.

These examples demonstrated that the a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as no effective management system were in place to assess, monitor and manage risk to people's health, safety and welfare.

During our visit we found the culture of the home to be open and warm. The manager was professional, courteous and proactive during our visit. Staff had a positive, can do attitude. They were friendly, welcoming and were observed to have good relations with each other and a kind approach to people's care.

We discussed our concerns with the manager, the turnaround manager and the assistant operations manager during the visit. We also provided feedback to the manager at the end of the visit. The manager acknowledged our concerns and showed a committed approach to ensuring that improvements were made to the service without further delay.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people were received person centred care that was appropriate and met their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The number of staff deployed was insufficient to maintain people's safety in some areas of the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured safe care and treatment was provided to people who lived at the home as risks to their health, safety and welfare were not appropriately assessed and managed. The provider had not ensured the premises were safe for their intended purpose.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.

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 an effective management system in place to assess, monitor and manage risks to people's health, safety and welfare.

The enforcement action we took:

We have issued the provider with a warning notice. This will be followed up and we will report on any action when it is complete.