Countrywide Care Homes Limited

Howgate House

Inspection report

Howgate
Idle
Bradford
West Yorkshire
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26 July 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 17 and 26 July 2018.

Howgate House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Howgate House accommodates a maximum of 63 people in one building over three floors.

There are communal rooms on two floors and there is an accessible outside area. The building has access for people with disabilities and there is a passenger lift to all floors. At the time of our inspection there were 53 people living at the home.

At the last inspection in September 2017 we rated the service 'requires improvement' overall. There were no breaches of regulations. During this inspection we found the provider had not sustained and built on the improvements they had made and we rated the service 'requires improvement' overall.

There was no registered manager in post when we carried out this 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.

A peripatetic manager was in charge of the service at the time of our inspection. People who used the service, relatives and staff spoke positively about the peripatetic manager. However, some concerns were expressed about what would happen when they were no longer based at Howgate House.

People told us they felt safe. However, we found there were not always enough suitably qualified staff on duty. The provider was not working to their planned staffing levels. There were occasions when agency nurses were in charge of the home without management support or the support of qualified care workers, known as care practitioners.

Staff received training on safe working practices. However, we found staff had not received training related to the particular needs of people who used the service.

Staff knew how to recognise and report any concerns about people's safety and welfare. The required checks on new staff were done before they started work and this helped to protect people.

We found the service was acting in people's best interests but this was not always reflected in the records.

People were offered a choice of food and drinks and snacks were available throughout the day. We found improvements were needed to the way people with more complex needs were supported to express their choices at meal times.

People's needs were assessed before they moved in. People were supported to access the full range of NHS services which helped to ensure their healthcare were met needs.

The home was clean and well maintained. However, we found staff on the first floor were hand washing crockery and cutlery and this was not in line with good infection control practices.

Staff supported people to maintain their independence. However, there was a lack of dementia friendly signage to help people find their way around the home.

People's medicines were managed safely.

Accidents and incidents were recorded. The peripatetic manager was putting processes in place to make sure lessons were learned when things went wrong and to reduce the risk of recurrence.

Staff were kind and caring and people told us they were treated with respect.

People's information was not always stored securely because office doors were left unlocked.

People were at risk of not consistently receiving care and support which met their needs and preferences because of shortfalls in their care records.

Complaints were investigated and responded to. However, a recent survey carried out by the provider showed an increasing number of people were not satisfied with the way their complaints had been dealt with.

There was a planned programme of activities but these did not always take place

The provider's systems for monitoring, assessing and improving the service were not being operated effectively. We found three breaches of regulations in relation to staffing numbers and staff training, person centred care and good governance.

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 always enough staff to meet people's needs in a timely way.

People's medicines were managed safely.

The home was well maintained and clean. However, staff were hand washing crockery and cutlery which is not good infection control practice.

People were protected from the risk of abuse and all the required checks were carried out before new staff started work.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training on safe working practices but there was a lack of specialist training to help them have a better understanding of the people's needs.

The service was acting in people's best interests but this was not always reflected in the records.

People told us they had a choice of food and drinks and snacks were available between meals.

People's needs were assessed before they moved in and people were supported to meet their healthcare needs.

The home had wide corridors. However, there was a lack of dementia friendly signage to help people find their way.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People with more complex needs did not always get the right support to help them make choices.

People told us and we observed the staff were kind and caring.

People were supported to maintain their independence.

People's information was not always stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were at risk of not consistently receiving care and support which met their needs and preferences.

Complaints were investigated but the provider's most recent survey showed an increasing number of people were not satisfied with the way their complaints had been dealt with.

There was a planned programme of activities but these did not always take place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The home did not have a registered manager.

Although the provider had systems in place to monitor, assess and improve the quality and safety of the service we found these were not being operated effectively.

Howgate 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 checked 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.

Before the inspection we reviewed information available to us about this service. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law. We also spoke with the local authority commissioning and safeguarding teams to gain their feedback about the service.

The inspection was carried out on 17 and 26 July 2018 and was unannounced on both days. The inspection team consisted of two adult social care inspectors and an assistant inspector. During the inspection we spoke with five people who lived at the home, four relatives, a visitor and a healthcare professional. We spoke with the peripatetic manager, the deputy manager, a night nurse, four care staff and the chef. We looked at seven people's care records, medication records and other records relating to the management of the home such as maintenance records, four staff files, training records, meeting notes and surveys. We observed people being supported in the communal rooms and looked around the home.

Requires Improvement

Is the service safe?

Our findings

There were not always sufficient numbers of suitably qualified staff on duty. At the last inspection in September 2017 we recommended the provider should keep staffing levels under review. Before this inspection we received information of concern about the staffing levels at the home and we asked the provider for information about the staffing levels. The peripatetic manager told us the service operated with six staff on night duty, one nurse and five care assistants. During the inspection we reviewed the duty rosters covering a four-week period from 25 June 2018 to 22 July 2018 with the administrator and peripatetic manager. There was only one night when there were six staff on duty overnight. There were five nights with only four staff on duty in total. There were ten nights without a member of staff on the twilight (8pm to 11pm) shift meaning there were five staff in total. On the remaining 12 nights there were five staff on duty overnight with an additional care assistant working the twilight shift.

The peripatetic manager told us the home operated with eleven care staff on duty in the morning. This consisted of one nurse, two care practitioners and eight care assistants. In addition, there were two hostesses to help with serving meals and drinks. In the afternoon the number of care assistants reduced by one, giving a total of ten care and nursing staff. The hostesses did not work in the afternoons or at weekends.

Our review of the duty rosters showed the numbers of staff on duty regularly fell short of the required levels. For example, during the week commencing 25 June 2018 the home failed to achieve these staffing levels on four of the seven days. On 25 June 2018 the home was short one member of staff in the morning and afternoon. On 29 June and 1 July 2018, the home was short two members of staff on the morning shift and on 30 June 2018, it was short one member of staff in the morning. On June 30 and July 1, 2018, the home was short two members of staff on the afternoon shift.

During the week commencing 2 July 2018 the home failed to achieve their full staffing on all seven days. On four mornings the home was short one member of staff and on the remained three it was short two. There were two afternoons when the home had a full complement of staff, (ten) and on the remaining five days they were short at least one member of staff.

During the following two weeks they failed to achieve their full staffing levels on eight of the fourteen days. Typically, the home was short one member of staff.

We also identified concerns regarding the skill mix of staff on day duty. For example, on Saturday 30 June, Sunday 1 July and Saturday 7 July 2018 there was an agency nurse in charge and no care practitioner on duty. The role of the care practitioner was to support nursing staff, for example by leading the staff team on one of the floors.

In addition, we found examples of agency nurses in charge handing over to agency nurses with no management oversight. For example, on the weekend of 7 and 8 July 2018 there was an agency nurse in charge of the on both days and both nights.

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

The peripatetic manager told us they were actively recruiting more staff to ensure they had cover for holidays and absence. They said short notice absence, when staff rang in just before the start of the shift or did not contact the home but did not turn up was the hardest to manage. They said they had put new processes in place to manage these situations. The peripatetic manager said they would put a process in place to make sure there was management oversight of any handovers where agency nurses were in charge of the home and handing over to other agency nurses.
The staff we spoke with had mixed views on the staffing levels. One said, "I think the staff levels are getting better." Another said: There's not enough. We need more, definitely, it's usually a lot less (number of staff) at the weekend." Some staff also expressed concern about the skill mix saying they did not think one nurse was enough. The peripatetic manager told us 34 people of the 53 people living in the home were assessed as needing nursing care.

A relative told us they thought there were not always enough staff around.

The provider had suitable arrangements in place to safeguard people from abuse. People told us they felt safe. One person said, "I've got nothing to moan about." Staff had received training on safeguarding. They knew how to identify and report concerns about people's safety and welfare. They told us they were confident the peripatetic manager would take appropriate action to address any concerns raised. The service reported safeguarding concerns to the relevant agencies and where necessary action was taken to reduce the risk of recurrence.

Records showed safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed.

The home was well maintained. The provider carried out a range of checks on the premises and equipment to help keep people safe. These included checks on the fire, electrical, gas and water systems. The peripatetic manager had carried out an audit of the fire drills and found the night staff had not taken part in a fire drill. This had been arranged to take place on 20 July 2018.

People's personal emergency evacuation plans (PEEPs) were in the main office. However, some of these had not been reviewed since people had moved into the home. One person's PEEP stated they were non-ambulant and non-weight-bearing. However, their assessment stated they were 'assessed over initial two weeks and able to weight bear and safely transfer with a handling belt and two staff.' Both documents had been completed on 19 July 2017. This was discussed with the peripatetic manager who said they would deal with it immediately.

On the first day of our inspection we observed staff were using the sink in the upstairs dining room to hand wash crockery and cutlery. This was not good infection control practice. The peripatetic manager told us this was an isolated incident due to the dishwasher breaking down. However, a relative told they had observed staff doing this on numerous occasions over the preceding months. On the second day of our inspection, the peripatetic manager told us the dishwasher had been repaired and this practice was no longer taking place. However, on three occasions we saw the upstairs dining room sink full of crockery and cutlery and staff washing these up. A staff member told us these were staff dishes that had not been returned on the trolley to the kitchen. It was clear from our observations that some of these were from people's meals. We reported our findings to the peripatetic manager who said they would deal with it.

The home was clean and staff had access to personal protective equipment, such as gloves and aprons and were using them appropriately. An infection control audit, completed on 13 November 2017 indicated a 95.51% score.

Medicines were stored, managed and administered safely. Qualified nurses and senior care workers took responsibility for administering medicines. We saw them doing this with patience and kindness, explaining to people what their medicines were for.

We looked at a sample of medication administration records (MARs) and saw people were generally given their medicines as prescribed. One person told us, "Medicines are always on time – never missed. They monitor, for example, Paracetamol. You've got to wait at least four hours between them (doses)." However, we saw some people's medicines which were required to be administered 30-60 minutes prior to food were not always given at the correct time. We spoke with the peripatetic manager who said they would review this and on the second day of our inspection they confirmed this had been done.

Medicines were audited monthly by senior staff and boxed medicines counted daily. An independent medicines audit had been completed by the local pharmacy in June 2018 and an internal medicines audit completed after this. We saw an action plan had been put into place following this, with dates for completion and any concerns addressed. We completed a random check of boxed medicines and found no concerns with these, although we found some duplicate stocks of prescribed creams and liquid medicines in place where both had been opened. The person administering the medicines on the day of our inspection immediately removed these for return to the pharmacy.

Accidents and incidents were recorded and reviewed every month to look for trends or patterns. However, we found each month was looked at in isolation and the absence of a cumulative analysis created a risk trends or patterns would not be identified. This was discussed with the peripatetic manager. They told us their analysis of the previous months accidents had identified many of the accidents and incidents which had occurred had been in the main lounge on the ground floor. In response to this they had spoken with staff about the need to maintain a staff presence in the lounge. To monitor this, they had implemented a checklist which staff had to sign every 30 minutes and this was monitored by the person in charge. The peripatetic manager told us this had already led to a reduction in the number of accidents. They also told us they had started reflective learning sessions for staff where they reviewed accidents and incidents and discussed how similar events could be prevented in the future. This showed us the peripatetic manager was putting processes in place to ensure lessons were learned when things went wrong.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive appropriate training and support to enable them to carry out their duties. New staff received an induction to the home and its ways of working. They were required to complete a range of induction training and shadow experienced staff.

There was a training matrix in place which used a traffic light system to highlight when staff training was due to be updated. The training matrix covered topics such as fire safety, infection control, safeguarding, food safety, dementia awareness and moving and handling. The matrix showed staff had completed most of the required training. Where there were gaps training had been scheduled.

Staff told us they did most of their training electronically. However, practical moving and handling training was also provided. We saw the deputy manager, who was a moving and handling assessor and 'champion', discretely observed staff to ensure best practice guidelines were followed. They told us they and two other staff members were trained moving and handling champions and trainers and received update training from an outside company to ensure they kept up to date with best practice. They then provided staff with annual practical training, as well as ongoing guidance and support with moving and handling techniques. If specific equipment was required, the service requested training from the company that supplied the equipment. We observed staff using the hoist to move people explained clearly and gently what was happening at each stage of the process to minimise people's anxiety.

Staff told us they had not received any specialist training related to the needs of people who used the service and this was supported by the training matrix. For example, when we asked one member of staff about training around Parkinson's and Epilepsy and they said, "No. It's something I'd like to be trained on. I've never done multiple sclerosis. We have a resident with that downstairs. I'd like to be trained on that."

Some staff we spoke with were unsure if they had received recent supervision or annual appraisal. A supervision is a one-to-one meeting with a manager to discuss work related issues, performance, objectives and career development. We looked at four staff records and were unable to find any records of supervision or appraisal from 2017 or 2018 for three of these staff. The fourth person had attended trial period discussion meetings in January, February and March 2018 but there was no record of any subsequent supervision meeting. We spoke with the peripatetic manager and deputy manager who told us these had been completed and there was a file which contained this information. The peripatetic manager spoke with the former registered manager on the telephone who confirmed this. However, this information could not be located during our inspection.

This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. The service was mostly acting within the MCA. People's capacity to consent to their care and support arrangements was assessed. The peripatetic manager understood their legal responsibilities under the Act.

Where people lacked capacity and it had been assessed that the accumulation of restrictions amounted to a deprivation of liberty, appropriate DoLS applications had been made. A number of applications were awaiting assessment by the local authority. There was one authorised DoLS in place, although the peripatetic manager was unable to find documentation to support this and told us they would contact the local authority for a duplicate authorisation. On the second day of our inspection, the peripatetic manager showed us an email they had subsequently received from the local authority confirming the DoLS was in place.

People were asked to consent before care and support was provided. Where people lacked capacity best interest decisions had been made involving families and healthcare professionals. However, we found in one instance, a best interests decision about the potential use of covert medication for one person had been made at their previous placement although no record of this was in the person's current care records. We saw the service had requested the information in December 2017 but this had not been sent. The peripatetic manager said they were aware of this and had chased the information since they had come into post. The person was not receiving covert medication at the time of our inspection.

We were satisfied the service was acting in people's best interests and therefore concluded this was a shortfall of record keeping. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service worked with other organisations to support people to meet their healthcare needs. Care records showed people had been seen by a range of healthcare professionals. These included GPs, community mental health nurses, district nurses, dieticians, speech and language therapists, dentists and opticians. The peripatetic manager told us they had a good relationship with the local pharmacist whom staff could speak with for advice and support. A visiting healthcare professional told us they had been working with the home for the past three years and had no concerns. They said the home supported some people with very complex needs and did this well.

Overall, we found people's nutrition and hydration needs were met. People who used the service told us meals were good. One person said, "Food is okay. I get plenty of coffee. It's lovely," and another commented, "I enjoy the food – I like everything."

In most cases we found people who had been assessed as being nutritionally at risk were being weighed regularly and referred to the dietician where required. Records were also being maintained of what they were eating and drinking. We found one person who had been gradually losing weight had not been identified as being at risk. We discussed this with the peripatetic manager and on the second day of our inspection we saw they had addressed it.

We spoke with the chef who explained they were given information about people's dietary needs and preferences. We saw information about this was displayed on a board in the kitchen. They explained how

they provided fortified diets when people were assessed as being nutritionally at risk.

There were choices available for every meal and an alternative was provided if people didn't want to eat what was offered on the menu. One person said, "They give choices – we're always asked for every meal. They come to take your meal order every day. You can have a salad if you don't want anything hot."

We saw people were offered a choice of hot and cold drinks throughout the day. For example, one person asked for a milk shake and staff went to the kitchen to prepare this for them. They returned with a full jug to offer this to the person and others in the sitting room. The person was clearly delighted and drank two glasses, remarking on how they were enjoying it. Snacks such as biscuits, and fresh fruit were also offered to people in between meals. We saw a 'hydration and snack station' had been set up outside the downstairs dining room, with jugs of juice, cups and packets of biscuits. However, we also observed in the upstairs lounge, the plastic box from which people were offered a biscuit, which was handed to them by a staff member, contained mainly broken biscuits. This was not an attractive way for a snack to be presented. In a similar vein we also observed staff serving tea in cups without saucers.

People's needs were assessed prior to them moving into the home to identify if the service could meet their needs. When people came to the home, a further assessment of their care and support needs was completed and this information was used to develop their care plans.

The home was well decorated with good standards of furnishings. Lounges were spacious and bright and dining rooms were set out nicely. There were dementia friendly pictures in corridors which were well lit and spacious to aid visibility and accessibility. There were very little other dementia friendly resources and there was a lack of good signage to help people find their way around. People's bedrooms were personalised and were decorated with photographs, flowers and personal belongings. The outside space was well designed with a seated decking area and we saw it was well used by people living at the home.

Requires Improvement

Is the service caring?

Our findings

People did not always get the right support to enable them to make decisions. People told us they were offered a choice of food at each meal time and we saw this worked well for people who could say what they wanted. However, we found it did not always work so well for people with more complex needs. On the second day of our inspection we saw a staff member brought a plate of food on a tray to show people in the dining room. They asked if the person was happy with this choice of meal, which they had agreed to on the previous day. However, the second choice from the menu was not shown to them. We overheard a staff member commenting to another staff member outside the dining room, "What's the point in offering?" We discussed this with the peripatetic manager who told us this was unacceptable and said they would investigate.

In another example at lunchtime we saw a person who was unsure what to do with their food, they said "What do I do with it?" A member of staff picked up a spoon and quickly put a spoonful of food into the persons mouth without any explanation, encouragement or prompting.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (9(3)(d)

People who used the service made the following comments about staff; "Staff are generally helpful and obliging, will do little things for you, above and beyond… they're very good." "It's alright here. The girls are nice; they're quite helpful." A relative told us, "My (relative) has been in here 19 years and we've never had any problems. No faults we can find (with) the staff, (and) the cleanliness."

We observed interactions between staff and people who used the service were mostly positive. For example, we heard staff complimenting people on how they looked, especially first thing in the morning and after visiting the hairdresser. At lunch time, we heard one person say "Can you get me a cushion? I can't reach my dinner?" and we saw a member of staff getting a pillow and helping the person to get comfortable in their chair. We saw the same member of staff gently supporting and encouraging a person to eat.

Care files contained information about people's life histories, interests and hobbies which helped staff to get to know them as individuals. People looked relaxed and comfortable around staff. There was a calm, friendly atmosphere. We heard some good-humoured banter shared between people who used the service and staff which resulted in laughter and further conversation. For example, a staff member assisting a person to the downstairs lounge asked, "Where would you like to sit, [persons' name}?" They answered, "On my bottom", at which both started to laugh and joke together.

We observed staff treating people with dignity and respect. For example, staff knocked on people's doors before entering and asked people's permission before delivering care and support. One person who lived at the home said, "They treat you like friends, but not silly. With respect. They respect what you have to say, like you would respect what they have to say."

At mealtimes people were encouraged to sit at large tables which promoted group conversation and helped to make dining a social occasion. We saw adaptive cutlery and crockery in use to assist people to eat independently and staff told us this had made a difference for people.

Staff encouraged people who used the service to be as independent as possible. One person told us, "Staff encourage me to walk every day. They ask, 'Have you had your walk today?' They just want to see you get better." Another person told us, "(Staff) help with my physio exercises to promote independence. I've got a self-propelled wheelchair. Staff will let me do it by myself. They will help when I want to start walking a bit."

Feedback from people and relatives about involvement was mixed. Some had been involved in care planning, others had not. The deputy manager told us the activities organiser held meetings with people who used the service but there was no record of these meetings available.
The peripatetic manager told us they were keen to support people to be involved in the running of the home. They said one person who lived at the home had been involved in the recruitment of staff and participated with meal time audits. The peripatetic manager told us the person had commented that this had made them feel important again.

Visitors were made to feel welcome. For example, we saw staff ensured enough seats were provided for people to spend time with their loved ones and offered visitors hot and cold drinks.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the registered manager, staff, people and relatives showed us the service was pro-active in promoting people's rights.

People's confidential records were not always stored securely. Although people's records were stored in a separate office downstairs and upstairs, when we checked these rooms throughout the inspection, we found they were not always locked.

Requires Improvement

Is the service responsive?

Our findings

Feedback about involvement in care planning was mixed, some people and relatives knew about care plans and had been involved with them and others did not. One person told us, "I've got a care plan in place. We've talked about it." A relative told us they had not had any involvement in their family member's care plan since admission.

Care records contained risk assessments relating to activities of daily living such as mobility, eating and drinking, continence and personal care. in most cases the risk assessments and care plans were up to date and had been reviewed monthly. However, in one person's records we found their pressure sore risk assessment and care plan had not been reviewed since April 2018; the person had been assessed as having a high risk of developing skin damage. The information in the care plan about the type of pressure relief mattress in use was incorrect. Although the person had not sustained any skin damage this created a risk they would not receive appropriate care. In another person's records we saw a care plan audit had been done on 14 May 2018 which stated the care plans were basic and not person centred. The care plans had not been updated following the audit and in addition we found they contained contradictory information about some aspects of the person's care.

This created a risk people would not consistently receive appropriate care which met their needs and preferences. This was breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The quality of the care plan reviews was inconsistent. Some reviews were generic, with the same set of phrases used for each review. Others we saw had resulted in care plans being updated and actions being taken in response to identified. For example, we saw the peripatetic manager had identified actions to assist staff with one person's behaviours that challenge.

Basic end of life plans were in place. However, some of these were not person centred and did not include information about people's specific wishes for this time. One person told us they were not yet ready to discuss plans about their future wishes. They commented, "We have discussed making alterations to the care plan when the time comes, such as end of life plans."

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. The provider had developed an accessible information policy and staff had received training on accessible information. We saw people's communication needs were assessed when they came to the service. The peripatetic manager told us there was no-one currently living at Howgate House who required specific communication support. They explained they used pictorial menus although we did not see these during our inspection.

The home employed an activities co-ordinator. A programme of activities was on offer, and people could

choose to participate in these or not. On the first morning of our inspection we saw people participating in gentle chair exercising and the same on the second day of our inspection. We also saw the activities coordinator spent time with people on a one-to-one basis on the first day of our inspection. On the second day of our inspection, the activities co-ordinator was not working and the activities board in the reception area showed nail care/massage and 'name that tune' was supposed to be taking place. We did not observe this.

We saw complaints were recorded, investigated and responded to. People told us they felt confident the peripatetic manager would act to address any concerns they had. However, in the 2017/18 surveys completed by people who used the service and friends and family we saw the overall satisfaction score for how the service dealt with concerns and complaints had decreased significantly from the previous year.

The service also kept a record of compliments to show where they had met or exceeded people's expectations.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in September 2017 there was a new manager in post. Prior to their appointment the home had been managed by a peripatetic manager. Following that inspection, the manager was registered with the Commission. However, they left the home in April 2018 and when we carried out this inspection the home was once again being managed by a peripatetic manager.

The peripatetic manager had a clear vision for the service and was committed to supporting the staff team to deliver person centred care. They were supporting all the staff through staff meetings and reflective learning sessions. On the second day of our inspection, which was unannounced, they had been in the home since 4am. They told us they had come in early to meet the night staff and ensure that as night workers they did not feel isolated from the rest of the staff team.

Staff spoke positively about the support they received from the peripatetic manager. One member of staff said, "Since [name of peripatetic manager] started, it just seems to be perking up now. Everything seems to be getting a bit better which is good." When we asked staff what improvements they would like to see they all said the home needed a permanent manager and better staffing levels.

Relatives of people who used the service also told us they had confidence in the peripatetic manager. However, some expressed concern about what would happen when they left. The peripatetic manager told us they would remain at the service until a new manager was in post.

The peripatetic manager told us they were preparing to send out surveys to people and their relatives for 2018 but was looking at creating a more user-friendly form for people to use. We looked at the results of the previous survey from 2017 carried out by an external organisation. The survey questionnaires had been completed by nine people who used the service and 17 family and friends. While there was an increase in the overall satisfaction score there were several areas where people were less satisfied than they had been when they completed the 2016/17 survey. In the responses from people who used the service these included how the service dealt with complaints, choices about daily routines and access to outside space. In the responses from friends and family these included how the service dealt with concerns and complaints, staffing numbers and the facilities. No outcomes or actions had been documented as a result of the questionnaire.

The provider had systems and processes in place to monitor and assess the quality and safety of the services provided. A range of audits were carried out on areas such as care plans, medicines management systems and people's dining experiences. In addition, the provider had a quality assurance team who carried out compliance visits and assessed the service against the Care Quality Commission domains. A report was produced following each visit and areas for action were identified.

However, during this inspection we identified breaches of regulations in relating to staffing, person centred care and record keeping. In addition, this was the second inspection where the service was rated 'requires improvement' overall. This showed the provider had failed to take effective action to improve the service.

This led us to conclude the providers quality assurance and monitoring systems were not being operated effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked the peripatetic manager how they kept up to date with best practice guidelines. They told us they attended monthly provider meetings and clinical governance meetings with other managers within the group to discuss issues and share best practice. They told us they researched best practice guidance and kept themselves up to date by looking on the internet and reading medical journals. They said they had received training in root cause analysis and attended provider seminars/conferences. Although they had not done so, they said they would attend the next local provider meeting to meet other managers and share best practice within the local area.

The service worked in partnership with other organisations such as the local authority and Clinical Commissioning Group (CCG) to promote good outcomes for people who used the service.

The peripatetic manager told us, and we saw posters displayed for a cheese and wine event being held the following week which was an opportunity for them to meet with people and their relatives. They told us they wanted to discuss setting up a residents and relatives association with regular meetings led by people, rather than them. They said, "They are the experts. We are only the passengers in this… It is good to have involvement; to involve people who use 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always supported and enabled to make decisions. 9(1)(3)(d) People were at risk of not receiving care which was appropriate and met their needs because their care records were not always detailed and up to date. 9(1)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes for assessing, monitoring and improving the quality and safety of the services provided were not operated effectively. 17(1)(2)(a) Accurate and up to date records in respect of each person who used the service were not always maintained. 17(1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified staff were not always deployed. 18(1) Staff did not always receive appropriate training and support to enable them to carry out their duties. 18(2)(a)