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Ashberry Court

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Ashberry Court is registered to provide permanent and respite care for up to 22 older people. There were 13 people living at the home at the time of the inspection. People required a range of help and support in relation to living with dementia and personal care needs.

There was a passenger lift at the home, due to the layout of the building, which included some split levels; a chair lift was in place to rooms which could not be accessed by the passenger lift.

This was an unannounced inspection which took place on 22 and 24 September 2015.

Ashberry Court had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

The manager was in day to day charge of the home. People and staff told us that they felt supported by the manager and told us they were always available on call to support them when needed.

The provider had not ensured that audits and systems had been maintained to ensure that quality and safety issues were identified and responded in a timely manner.

Environmental risk assessments had not been completed. This included fire and legionella checks.

Fire evacuation procedures needed to be improved to incorporate different staffing levels at night. Personal evacuation procedure information was not in place in event of an emergency evacuation.

Documentation needed to be improved this included identifying people's choice and involvement in decisions, for example bathing and showering. We also found documentation for medicines needed to be improved.

Peoples dignity had not always been maintained, we saw that when people had spilt food down their clothes they had not been supported to change.

Daily charts including repositioning and nutritional charts had not been completed accurately to ensure peoples skin integrity and nutritional intake was safely monitored. This meant it was not clear that people received appropriate care too meet their needs.

Staff had not received appropriate training to support the needs of people living in the home. Supervisions and appraisals had not been completed. This meant that staff did not receive guidance to ensure they were suitably trained and supported to meet the needs of people living in the home.

Notifications had not been completed to inform CQC and other outside organisations when notifiable events occurred.

Recruitment checks were completed before staff began work.

Staff demonstrated a clear understanding on how to recognise and report abuse.

Referrals were made appropriately to outside agencies when required. For example GP appointments, dental appointments and hospital visits.

Feedback was gained from people this included questionnaires.

We found breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Procedures for medicines were not always safe. Protocols were not in place for all 'as required' medicines.

Risk assessments were not in place to ensure people's safety was maintained.

Fire risk assessments and personal emergency evacuation procedures had not been completed.

Areas of the building presented a risk to people. An unlocked cupboard in a communal area contained hot pipes. Regular safety checks including legionella and hot water checks had not been appropriately completed.

People told us they felt safe and staff knew what to do if they suspected anyone was at risk of abuse.

Recruitment checks were completed before staff began work.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had not received effective training to ensure they had the knowledge and skills to meet the needs of people living at the service.

Staff had not received regular supervision and appraisals.

Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS)

The provider had not ensured people's nutrition was monitored effectively. People's weights were not consistently documented.

People had choice at meal times, with alternatives available when requested.

Referrals were made to outside professionals if required.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's dignity was not always maintained.

Staff knew people well and displayed kindness and compassion when providing care.

People were involved in some day to day decisions and given support when needed.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

Computer and paper records did not always correlate. Some significant information had not been included in daily records.

People's choices in relation to baths and showers was not clear.

Care plans had not been reviewed regularly to ensure information about people was current and accurate.

A complaints procedure was in place, this needed to be updated to ensure information was accurate.

Daily activities were provided for people however these did not always reflect people's interests and preferences. The manager was in the process of improving activities offered to people.

Is the service well-led?

Inadequate

Ashberry Court was not consistently well-led.

Audits had not identified issues relating to regular reviews of care or that documentation needed to be improved.

The registered manager was not aware of changes to the regulations and how this impacted on the way the home was managed.

Policies and procedures were out of date.

Notifications had not been completed for all notifiable events.

The provider had not carried out regular checks to ensure good governance had been maintained.

Staff felt supported by the manager and told us that they were always available if needed.

The home had a registered manager.

Ashberry Court

Detailed findings

Background to this inspection

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

This inspection which took place on 22 and 24 September 2015 and was unannounced.

The last inspection took place in June 2013 where no concerns were identified.

The inspection team consisted of two inspectors.

Before the inspection we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and investigations, and any other information that has been shared with us.

A Provider Information Return (PIR) had not yet been requested as the inspection had been bought forward due to concerns raised with CQC. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Not everyone living at Ashberry Court was able to tell us about their experiences of living at the home. We carried out observations in communal areas, case tracked three peoples care documentation in full and looked at specific care documentation for a further three people. This included risk assessments and associated daily records, charts, Medicine Administration Records (MAR) charts and medicine records. We read diary entries and handover information completed by staff, policies and procedures, accidents, incidents, quality assurance records, staff meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for three staff and records of staff training for all staff.

We spoke with five people using the service and seven staff. This included the registered manager, care staff, kitchen staff and other staff members involved in the day to day running of the service.

There were no relatives or personal visitors to the home during our inspection. However, we spoke to a visiting nursing professional during the inspection. And a further two visiting professionals after the inspection.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Ashberry Court. One person told us, "They know how to look after me." And another said staff, "Are here, and I'm safe."

Despite this positive feedback we found that the home did not always ensure people remained safe at all times. There was no fire risk assessment carried out by a trained professional to ensure the building met safety requirements in the event of a fire. There was a passenger lift at the home and due to the layout of the building, which included some split levels; a chair lift was in place to rooms which could not be accessed by the passenger lift. People had varying mobility needs with some requiring full assistance to evacuate the building. There were no personal emergency evacuation procedures in place to identify individual evacuation safety requirements for people. For example, mobility or health related conditions which may affect their ability to evacuate safely in the event of an emergency. Therefore, it was unclear how many staff would be required to assist people living in the home in the event of an emergency. A fire procedure policy was in place; however it was not clear when this had last been reviewed. During our inspection we found fire doors had been propped open by staff using magazine racks. This meant that fire doors would not shut automatically in the event of a fire. We saw this on both days in the communal lounge and one person's bedroom.

There were policies and procedures for the management of medicines including information for PRN or 'as required' medicines prescribed by people's GPs. There was PRN guidance for paracetamol but guidance was not in place for all PRN medicines being administered. This included PRN medicines being given to people on a daily basis for pain relief. PRN guidance is to ensure that all PRN medicines are given in a clear and consistent way, regardless of who is administering them. People may be at risk of not receiving medicines safely or consistently. Staff told us that one person self-administered their pain relief, however, no information was found in their in care plan regarding this and no risk assessment had been completed.

Individual risks to people due to their health, mobility and care needs were not always identified to ensure people remained safe. Risk assessments had not been completed to ensure that people who chose to self-administer their medicines were safe to do so. Daily temperature checks are required in areas used to store medicines. This is to ensure that medicines are stored at the correct temperature to prevent any deterioration of medicines. Temperature checks in the medicines room had not been completed since 15 September 2015. Staff told us this was because the thermometer had gone missing. No action had been taken to rectify this. The manager told us they would ensure a new thermometer was purchased.

Some people who had skin creams prescribed by their GP had care plans in place, however these only stated to apply the prescribed cream. It did not state what the cream was or why it had been prescribed. This meant that information was not clear for people who had more than one cream prescribed. We found that one person had a cream prescribed for a specific health related reason. The manager told us that this cream was applied regularly. However, no guidance for this health condition was seen in their care plan to inform staff that cream should be applied to treat this ailment when the person experienced pain or discomfort. We found a topical analgesic cream in one person's bedroom. It was unclear if they were self-administering this prescribed cream, or whether this was safe to be left in this person's room. We asked the staff who were not aware whether the cream was currently being used by the person.

People living at the home for a period of respite care did not have photographs in place in the MAR charts to ensure staff were able to confirm their identity when administering medicines. Information on documentation was not always clear and legible. MAR charts had not always been completed in black pen. This had been identified in a recent audit as an area that needed to be improved, however we found recent entries where red pen had been used.

All the issues above meant that the provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored tidily in the medicines trolley. Medicines had been dated on opening and there were systems in place for the ordering and safe disposal of medicines. Staff had received medicine administration training and new staff were not able to give people medicines until their competencies had been checked and they were safe to do so.

Requires improvement

Is the service safe?

People may be at risk if water systems are not adequately maintained. The manager was unable to locate a current legionella certificate to show that a risk assessment of the water system had been completed by a certified professional. The manager told us they thought this had last been done approximately two years ago. People may be at risk of possible bacterial infection if water systems are not adequately tested and maintained. Water temperature checks were being done by staff around the building, however, no guidance was in place to inform staff what they should do if temperatures did not remain within the stated perimeters to prevent bacteria. We saw that although temperatures had been logged, no action was evident when temperatures were identified as below the required temperature.

We found a cupboard in a communal area on the lower ground floor housed hot water pipes. This cupboard was not locked. People with dementia and memory loss may be at risk of consuming substances which may cause harm if these are not safely stored. The laundry room, which contained items included in the homes Control of Substances Hazardous to Health (CoSHH) folder as potentially dangerous was not locked and the door was left open throughout the day with open boxes of washing powder and bottles of fabric softener left within sight.

The home had designated domestic staff who worked at the home throughout the week. Although the home appeared generally clean and tidy there was an odour of stale urine in the communal lounge and in two of the bedrooms. We saw that domestic staff had daily charts in place to sign to show tasks had been completed. The manager told us they carried out a daily walk around and identified any extra areas of cleaning required. This was then completed by the domestic staff. We saw that the home had a carpet cleaner, and that regular carpet cleaning had taken place around the home. However, the odour in the lounge was still obvious. The manager arranged for the carpet to be lifted overnight and it was found that the odour of urine was coming from the underlying floorboards. A deep clean of the floorboards was completed and the odour was not obvious on the second day of the inspection. Although rectified, this was done in response to the inspection and had not been identified by staff or the manager. Carpet cleaning in people's bedrooms although completed had not always rectified the issue. It was unclear what plans were in place to manage this effectively. We spoke to professionals who visited the service and they told us that they had noticed an odour around the building and in people's bedrooms.

These issues meant that the provider had not ensured all premises and equipment was properly maintained. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding training had taken place for most staff and further training was booked to take place in the coming weeks. Staff displayed a good knowledge and understood their responsibilities to recognise and report any safeguarding concerns. There was up to date contact details for reporting concerns displayed in the manager's office. Staff told us they would raise concerns with the manager and that they had a responsibility to raise concerns directly with the local authority if this was not possible. Staff were clear that their priority was to protect people and ensure they were safe from the risk of abuse.

Regular maintenance checks had been completed on gas, and electric appliances including annual Portable appliance testing (PAT). Equipment used for moving people, including hoists and stair lift had been serviced regularly to ensure they were safe to use.

Accidents and incidents were logged and analysed by manager. However these were not always completed by the person who witnessed incidents, or the person who dealt with the incident but handed over and completed by someone else. This meant that information provided on the form was not 'first hand' and lacked detail. There was however analysis completed to ensure that any trends and risks were identified to prevent reoccurrence if possible. The manager and staff understood the importance of learning from incidents to facilitate continued improvement within the service.

Recruitment information was available. References and relevant checks had been completed before staff began work, for example, disclosure and barring service (DBS) checks, A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Requires improvement

Is the service effective?

Our findings

People told us that staff were, "Ok, they seem to know how things should be." Staff told us that they had training regularly and that training they received enabled them to understand people, for example dementia training had helped them provide appropriate care for people with dementia. However, staff felt that they did not receive training to support them in providing care to people with behaviours that may challenge or supporting people with mental health conditions. Staff were able to access further opportunities for professional development in the form of diplomas in healthcare if they wished.

We looked at training for staff. The manager was unable to give an accurate list of all training that had taken place and told us this was a task which had been delegated to another member of staff who had recently left the service. The manager had been unable to locate all the information to clarify all training completed by staff. To rectify this they had begun booking further training in areas which appeared to be out of date. People may be at risk of receiving inappropriate care and treatment if staff training is not up to date. For example we were unable to find evidence that all care staff had received infection control, medication and equality and diversity training. Moving and handling training was out of date and training had been booked for some staff to attend in the near future. The provider had not ensured that staff providing care and treatment had the appropriate training, competence and skills to do so. Many people living at Ashberry Court had dementia or memory loss. It was unclear how many staff had attended dementia specific training to ensure people living at Ashberry Court received appropriate care to meet their needs.

Staff had not had regular supervision in accordance with the organisations policy which stated that all staff should receive regular formal supervision. Regular supervision ensures that staff are adequately supported to provide appropriate care to people. The manager confirmed that this should take place every two months, but had not been completed. They told us 'Ad hoc 'meetings had taken place between some staff and the manager to discuss issues when they arose. However, they had not always been documented. The manager was unable to locate the supervision plan. Staff told us they could not remember when they had last had supervision. This meant that the manager did not have a system in place to adequately support staff on a one to one basis. Supervision allows staff and managers to identify areas for development and listen to staff ideas and concerns. Appraisals were scheduled to take place in September. At the time of the inspection these had not commenced. This meant that the manager did not have a system in place to give feedback to staff to facilitate on-going development.

These issues meant that the provider had not ensured staff were suitably trained and supported. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff had a period of induction and were supported throughout this time by management and other care staff. The manager told us they had recently begun using the new Care Certificate Standards induction for new care staff. The Care Certificate sets out the learning outcomes, competences and standards of care that are expected from care workers to ensure they are caring, compassionate and provide quality care. We looked at staff induction files and found that these had not always been fully completed to show that inductions had been completed. This was an area that needed to be improved. The manager told us this had been an oversight and the induction had been completed. Staff said that they had received a period of induction which had helped them when they started working at the home.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need but there may be a need to restrict their movements in some way in order to be able to do this. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The manager understood the principles of DoLS, how to keep people safe from being restricted unlawfully and how

Is the service effective?

to make an application for consideration to deprive a person of their liberty. At the time of the inspection there were two DoLS authorisations in place. The manager had followed correct processes and made referrals appropriately. Staff understood why some people had a DoLs in place and the specific restrictions this placed on them.

We observed staff asking people for consent before providing care. Staff described how they would ask for people's permission before giving support, and what they would do if someone declined the support offered. We observed staff involving people in decisions and speaking to people to ensure they were involved in how they received care and spent their day. In the lounge we saw that staff sat with people whilst asking them their meal choices and involved them in decisions about how they spent their day. In care files we saw that one person had read and signed part of their care planning documentation to show that they agreed to what had been written. One person living at Ashberry Court had an independent advocate which had been arranged by the manager. People were supported to make choices and decisions.

Referrals had been made to other health professionals when required. This included GPs, community nurses and a visiting podiatrist. The manager contacted outside professionals, for example, one person needed to see the GP as they were feeling unwell during the inspection.

Referrals had been made appropriately to Speech and Language Therapist (SALT). There was Information in people's care plans with regards to advice provided in relation to eating and drinking. We looked at the care file of a person who had been identified as at risk of poor nutrition due to their health related condition. Daily food and fluid charts had been started, however this information had not been documented daily over the last week, and some days had no information completed. People may be at risk if their nutrition and fluid intake/output is not effectively monitored. The manager spoke to staff who told them that they did not think it was necessary to continue completing daily charts as they thought the person's health had improved. The manager told us no decision had been made and this had not been discussed in handover. It was unclear why staff had made this decision without a review of the person's care being completed with the manager.

Care plans stated the regularity that people should be weighed. Weights should be monitored to identify any changes to people's overall health. For people who had reduced appetite or health related conditions risk assessments are completed using people's weights as a guide. These are required to access their risk of skin breakdown. Weights had been completed for some people, however when this had not been completed it was unclear whether this was an omission or whether the person had declined to be weighed.

This meant that people were at risk as nutrition and fluid intake was not being effectively monitored in accordance with their care plans. These issues meant that the provider had not ensured peoples nutritional and hydration needs. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the food was, "Very nice." And "Ok they give me something else if I don't like what's being made". We saw that there was a menu plan which was flexible and alternatives were available. People were asked in the morning their choice for lunch and this was documented. We saw that a number of variations and alternatives had been provided over previous days. Only three people chose to sit and eat in the dining room, one person ate in the lounge. We spoke to one person who ate in their bedroom who told us this was their choice as they preferred to eat in their own room.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us that they thought staff were caring. We saw that some staff sat with people and took the time to interact with people in a positive manner.

Staff told us that they, "Worked together as a team." A number of people living at Ashberry Court did not use the communal areas throughout the day. One person went out daily and others chose to stay in their rooms. People who stayed in their rooms told us that staff came in to see them if they used their bell or when they were bringing drinks or food to them. We saw one person who was feeling unwell and was staying in bed that day; staff took the time to pop in regularly to check they were ok and sat with them to chat on a number of occasions. This person told us that staff. "Keep an eye on me I am not feeling well, so they check I am alright and come in and talk to me."

Staff knew people well and how they had care provided. Staff told us when people had showers and how people spent their time. Documentation in place and the way care was provided by staff appeared primarily task orientated and did not evidence a person centred approach to care. It was not clear from documentation how evidence based decisions had been made about people's care. Staff made changes when they felt this was appropriate and not according to best practice or after reviews of care. For example, the discontinuation of daily repositioning, food and fluid charts. Changes had not been discussed with people to show they were actively involved in making decisions about their care. We saw that when staff were asked by the manager to do something for one person, they had not taken this forward for other people. For example, when asked to document something specific for one person this had not been incorporated into other people's care files.

There were no visitors during the inspection and staff told us that a number of the people living at Ashberry Court did not have regular visitors although this was encouraged. Only three people accessed the lounge during the inspection, staff told us it was normal that these three people were in the lounge. Staff members spent time sitting in the lounge. They engaged in conversation about day to day news and discussed the newspaper. People interacted positively with staff and told us that they, "Liked chatting when staff had time to sit down."

People were dressed appropriately for the weather conditions. One person told us they liked to wear their skirts and we saw that this was what they were wearing. Some people did not want to get dressed or declined assistance with washing and dressing most days. Staff told us this was people's choice. However, it was not clear from documentation or talking to staff when they would intervene or seek support from outside agencies or professionals when this was in the person's best interest or a risk to their health and safety.

People's dignity had not been supported. We saw that one person sat in the communal lounge in the afternoon had food staining down the front of their top. Although staff had acknowledged this no-one offered to help the person change their top or support them to remove the food marks from their clothing. This was an area that was required to be improved to ensure people's dignity was maintained at all times. The manager told us they did not have an allocated dignity champion at the home. However this was an area they included in discussions at meetings.

People receiving personal care had their doors closed. We heard staff knock on doors before entering and asking people if they could enter their room. People who were able to go out alone were supported to do so. However, this had not been appropriately risk assessed in care files. One person was very particular about where things were kept in their bedroom. Staff supported this when safe to do so but where aware when requests could not be met if this posed a risk to the person's health, safety or an infection control issue.

People had access to call bells and we saw that people received assistance in a timely manner when they used the call bell to alert staff that they needed assistance.

We discussed advocacy services with the manager. They told us that they were considering contacting an advisory service to obtain an advocate for someone living at the service who they felt would benefit from this support. This would be done with the agreement of the individual.

Requires improvement

Is the service responsive?

Our findings

People told us that they felt that the home provided them with the care and support they needed.

Daily notes were completed on a computerised care system accessed on computers in the manager's office. Some paper documentation was also being used to document personal care, baths, showers and daily charts including repositioning, food and fluid intake. Some information was being documented on both the computer system and on paper charts. However, this information did not always correlate. We saw daily charts had not been fully completed, for example, paper documentation identified weeks when people had not received baths or showers.

We also found that daily nutritional and repositioning charts had not been completed daily as specified in people's care plans. This meant that it was difficult to get a clear picture regarding personalised care provided for people.

People's choice and involvement in decisions was not always clear from care planning, assessments and daily records. For example, information regarding people's choices in relation to baths and showers had not been clearly recorded to show whether people had been offered a choice or had declined. This meant that for some people it was not clear whether they had been offered a bath or shower over a number of weeks. The manager was aware that this information needed to be clearer and felt this was due to staff not documenting all care that was offered and provided.

People may be put at risk if documentation is not always complete and accurate. Accident and incident forms had been completed for example when a person had fallen in their room, but this information was not always documented in the daily records on the computer system, or clear from hand written records in people's care files.

People were at risk of receiving inappropriate care and treatment as documentation did not provide staff with information about people's current support and care needs. We found a number of care plans which needed to be reviewed to ensure the information was up to date and accurate. For people who staff told us had behaviours which may challenge or specific mental health diagnosis, care plans did not include information to support staff in providing care to meet these needs. Specific guidance was not in place to inform staff of individualised care for people when they displayed behaviours that may challenge, including triggers and appropriate actions.

Care plans were in place for identified care needs. This included information for specific health related conditions including, diabetes. These were clear, however not all reviews had taken place monthly as specified. Diabetes information provided support to staff on how to recognise and respond if the person became unwell due to their diabetes.

Documentation was not consistent. Some staff wrote clear daily notes including all care provided whereas others were task specific and did not include information about people's mood and behaviours. Documentation did not evidence people's consent being gained or any involvement in assessing and planning of care. One person had asked to see a specific area of their care plan and had signed this to confirm they had read it; however, this had not been dated so it was unclear when this had taken place.

One person had been living at the service for a few weeks, had originally moved to the home for a period of respite but had now moved in permanently. A care file was in place. However, this did not include all areas of care documentation for this person. Including whether they were safe to go out alone and issues relating to their medication, personal care and behaviour. The care file stated that this person could display agitation and aggressive behaviour. No care plans or risk assessments were in place to support staff with regards to this.

People had the opportunity to share their views and give feedback by completing resident questionnaires. People who were unable to complete these had been assisted by care staff. It was not clear whether people had been offered the opportunity to have an independent person support them in the completion. Feedback from people had been reviewed by the manager. Actions had been documented, this included improvements with regards to food. The manager told us that a new cook had begun working at the home to ensure improvements continued.

A complaints policy and procedure was in place, however this needed to be updated as some of the contact information was incorrect. Copies were also given to people as part of the information given on admission.

Requires improvement

Is the service responsive?

People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. We looked at a previous formal complaint received by the service. We saw that the provider had responded in writing to the complainant. However, this had not been done within the timescale as stated in the homes' complaints policy. The manager told us the complaint had been resolved and the investigation completed. We saw a copy of letters sent to the complainant but it had not been dated to show when this complaint had been closed. This was an area that needed to be improved to ensure a clear audit trail of investigation into complaints received.

A daily programme of activities was displayed. The manager told us that this was a guide and was flexible. This included a visiting musician and singers who had provided entertainment in recent weeks. Although there was a schedule in place these did not reflect people's individual choices, past interests or hobbies. The main lounge which was used on a daily basis had a television which was turned on throughout the day. Staff told us that they had special occasion activities, for example tennis week, Christmas and Easter, but on a daily basis activities were limited. There were games and books in the lower ground communal area but we did not see anyone access these. On the second day of the inspection the manager asked staff to take some items to the lounge to use in an activity which they did. One person was being assisted to knit, and they told us this was their, "Favourite way to spend their time." People who stayed in their rooms told us they watched television and sometimes came to the lounge but not regularly. They said it was, "Only if something was happening." We discussed activities with the manager who told us that they had attended an activities forum accompanied by a member of staff. This had given them some useful guidance and they were in the process of implementing a new activities folder to gain more information from people regarding their hobbies and activities they would like to be involved in. Staff would also use these folders to document who attended activities to give clearer feedback.

These issues meant that the provider had not ensured people received person centred care to meet their needs and reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager at the time of the inspection. The manager and staff told us that the manager was available on call at all times. We saw occasions when the manager had been contacted in an emergency and had supported staff when issues occurred, for example during a power cut.

People told us that they spoke to the manager and would go to her if they needed to discuss anything. Staff told us that the manager was always available.

Despite this positive feedback we found that the manager did not demonstrate that there was an open, transparent culture within the home and the way care was provided. They were unaware of a number of changes to regulation and were unable to demonstrate an understanding of how this impacted on the way care was provided at the home. For example, the manager was not aware of 'Duty of Candour'. The Duty of Candour is a regulation that all providers must adhere to. The intention of the regulation is to ensure that providers are open and transparent and sets out specific guidelines providers must follow if things go wrong.

Areas of the home had not been managed to ensure that standards of care had been maintained.

Policies and procedures were in the process of being updated. The manager had started this process, however we found that some policies had not been reviewed for two years and were out of date. Disciplinary, infection control, CoSHH policies and guidance on infectious outbreaks had recently been updated and were available for staff to access if required. Staff were not aware of the whistleblowing policy but told us that they would speak to the manager if they needed to raise a concern.

Care documentation had not been audited to ensure that it was fully completed and reviews undertaken. The manager had not identified that daily charts had not been completed by staff or ensured that reviews had taken place. Training schedules had not been maintained, and the manager was unable to locate information to show that maintenance and risk assessments had been completed with regards to fire and maintaining water systems.

There were no documented audits completed by the provider to identify any areas of concern. We saw that two visits had taken place in January and July 2015, however these did not identify that the provider had checked systems and auditing to ensure good governance had been maintained.

Environmental audits completed by the manager and staff had not identified areas found during the inspection, for example odour in people's rooms and communal area. Audits had been completed for medicines; this included a further audit completed by the pharmacy providing medicines to the home. However we still found areas relating to medicines which needed to be improved.

We asked the manager what support and supervision they received from the provider. They told us that they could contact the provider if needed. However, they had not received any formal supervision by the provider. This did not demonstrate the provider had an overview of what was happening at the home or ensured the manager was supported with a system of regular supervision.

The manager and provider had not completed required notifications to meet registration requirements. This included deaths within the home which should be sent to CQC as a notification.

These issues meant the provider did not have systems in place to assess, monitor or improve the quality of services provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager carried out staff meetings. We looked at minutes of meetings and saw that discussions had taken place to remind staff of their responsibilities whilst working at the home. We saw a number of signs displayed in the manager's office and staff areas reminding staff of the correct practice they needed to follow. For example accurate completion of MAR charts.

There had been some issues within the home over recent months which had led to staff being disciplined. The manager had sought support from an outside legal organisation to ensure that they followed appropriate guidance and legislation when dealing with staffing issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The provider had not ensured all premises and equipment was properly maintained.** 15(1)(a)(c)(e)

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 people received safe care and treatment** 12(2)(d)(h)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider had not ensured staff were suitably trained and supported.** 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had not ensured people received person centred care to meet their needs and reflect their preferences.** 9(1)(a)(b)(c)(3)(a)(b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider had not ensured peoples nutritional and hydration needs had been met.** 14(4)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess, monitor and improve the quality of service that people receive. 17(1)(2)(a)(b)(c)

The enforcement action we took:
Warning Notice