Ashfields Care Limited

# Ashfields Care Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

We inspected the service on 8 and 9 December 2016. The first day was unannounced and the second day was announced. Ashfields Care Home is a nursing home which provides support and nursing care to up to 46 older people, some of whom live with a dementia related condition. Two beds in the service are designated enhanced beds for people who are nearing the end of their life. On the day of our inspection 46 people were using the service.

The service had a registered manager in place at the time of our 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.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were not being assessed and planned for to protect them from harm.

People did not receive the support they needed from staff to ensure they received care and support when they needed it. Medicines were managed safely and people received their medicines as prescribed.

People were supported by staff who did not have all the skills needed to meet people's individual needs. People were supported to make certain decisions and staff knew how to act if people did not have the capacity to make decisions.

People may not receive the support they require to maintain their nutrition although staff were monitoring and responding to people's health care requirements.

People who were receiving end of life care were not assured this would be managed effectively and without unnecessary discomfort and pain. People did not consistently receive care in a kind and compassionate way or have their needs responded to in a timely manner.

People were not provided with the care and support they required in a well-planned and organised manner. People were provided with opportunities to participate in social activities and felt that any concerns or complaints would be listened to and acted upon.

Although the new registered manager had made some improvements people were not using a service that was consistently managed and well run on a day to day basis. Systems to monitor the quality of the service were being implemented, but these had not been in place for sufficient time to identify where improvements to the service could be made.

During the inspection we found breaches of the Health and Social Care Act 2008 (regulated Activities)

Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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.

People were at risk of harm because the system to assess any risks they may face was not effective.

People could not be assured there were staff available who would be able to meet their needs.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as prescribed and medicines were managed safely.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People were not provided with the support they needed to have the nutritional intake they required.

People were supported by staff who did not have all the skills and knowledge they needed to care for individuals needs.

People were able to make decisions in relation to their care and support and when they needed support to make decisions they were usually protected under the Mental Capacity Act 2005.

People's health was monitored and responded to appropriately.

### Is the service caring?

**Inadequate**

The service was not caring.

People who required end of life care were not always provided with compassionate care in a way that ensured they were as comfortable and with as little pain as possible.

People may not be cared for in the manner they preferred as they were not always consulted. People were generally treated with

respect and had their dignity maintained.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People were not always supported in consultation about their preferences and how they would be supported. People did not have a clear plan of the care and support they required and they did not always receive care in a responsive way.

People were able to raise issues and staff knew what to do if issues arose.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a lack of appropriate governance and risk management framework and this resulted in negative outcomes for some people who used the service. There was a lack of clear direction and leadership for staff.

The views of people who used the service and their relatives had not been listened to and acted upon prior to the new manager taking up post.

# Ashfields Care Home

**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.

We inspected the service on 8 and 9 December 2016. The inspection was unannounced. The inspection team consisted of two inspectors, a specialist advisor who was an end of life care specialist nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. Before the inspection, the provider completed a Provider Information Return (PIR). This 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.

During the visit we spoke with eight people who used the service and the relatives of seven people. We also spoke with a health and social care professional who was visiting the service.

We spoke with nine members of support staff, two qualified nurses, the cook, a house keeper, the maintenance person, two administration officers, the activity organiser, the registered manager and the provider. We looked at the care records of seven people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

# Is the service safe?

## Our findings

People did not always receive the care and support they needed when this was needed. With the exception of one relative, all of the people who used the service and their relatives told us they felt there needed to be more staff as they did not feel support was given in a timely way. One person who used the service told us, "I think there are enough but could do with more. When I ring the buzzer they usually come straight away but it took an hour once. It depends on what they are doing." Another person told us, "Sometimes there are enough staff. They could do with more. Sometimes they are a bit stretched at times." A third told us, "Some of them don't turn up. I need two people to bathe me but sometimes I have to wait. Staff are stretched with other people's needs." Relative comments included, "In the first few weeks here [relation] would ring the buzzer and needed two helpers to come. Once or twice [relation] waited 45-50 minutes when they wanted to go to the toilet."

People were not always supported in a timely way and we found staff did not communicate well with each other to ensure people got the support they needed when this was required. We observed there was a general lack of effective leadership on the floor and this resulted in a lack of staff presence at times when it was needed. Some staff said they were not always provided with all the information they needed in the handover held at the beginning of the shift, particularly if they had been off the proceeding day.

We observed many occasions when there were no staff present in the main lounge and in the dining room at lunchtime there were occasions when there were no staff present, despite a number of people needing support to eat. On the afternoon of our second visit we entered the main lounge and a person told us that another person needed some help from staff and asked if we would fetch one. We asked the person if they had access to a call bell so they could summon staff and they told us they did not. It transpired that the emergency bell was a portable one and a person who used the service had taken it to their bedroom. This meant people did not have any way of summoning staff when they needed assistance.

We observed that staff sometimes walked through the lounge areas without acknowledging anyone and did not stop and speak with people or notice what was happening. We saw one occasion when a person who lived with a dementia related illness was given unopened mousse by catering staff as a snack to aid their nutritional intake. We observed the person try to eat the mousse by licking the lid and then gave up for a short while. They then tried getting the lid off but were unsuccessful. Staff who walked through the lounge did not see the difficulties the person was having so did not offer them the assistance they needed. Eventually a member of staff came into the lounge and did notice the person trying to eat the mousse and supported them with this. However this was purely by luck rather than effective communication from catering staff to care staff. We observed another person who required assistance to eat was given a similar mousse during the mid-morning snack round and was told staff would be "along to help shortly." We saw from the records that the person was not assisted until 30 minutes later, which was then only an hour before lunchtime.

Staff told us there had been significant improvements to the number of staff on duty made since the new registered manager had taken up their position. They described how difficult it had been prior to this

improvement to provide people with their care. They gave examples of people not having their breakfast until mid to late morning so they were not eating their lunch. They told us how this had led to them prioritising the most important tasks; such as ensuring people had their breakfast in good time. However this meant they had not been able to support people who needed assistance with getting washed and dressed until mid to late morning. Whilst staff recognised this staffing increase had been a significant improvement they still spoke of problems in meeting people's needs at key times, such as mealtimes, in a timely way. This was due to the number of people who were dependent on staff assistance with their daily routines. The registered manager told us they had identified this as an issue, but felt it was more of a case of staff not working effectively rather than insufficient staff, but they agreed that at times people did not receive the care and support they required when they needed this.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals were not properly assessed or managed to ensure staff had access to information about how to manage the risks. Staff said one of the ways they kept people safe was by following any risk assessments that were in place for each person. They said these covered such areas as using any equipment that assisted people with their mobility, which described the correct way to use this to support each person. However we found that risk assessments undertaken were not robust and did not always lead to an appropriate care plan being put in place to guide staff in supporting people in minimising these risks. People and their relatives we spoke with described people having suffered falls in the service. One relative told us, "[Relation] had a fall" and another relative told us, "[Relation] has had a few falls here."

We looked at the records of one person who had been assessed as being at very high risk of falling. There was very brief information in relation to this detailed on the person's overall care summary, which stated the person needed a crash mat at the side of their bed in case they fell from bed. There were no risk management strategies on the risk assessment and a lack of care plan detailing how staff should manage this risk when the person was in their bedroom alone. A sensor alarm had not been considered, which would alert staff if the person fell in their bedroom. We visited this person in their bedroom in the afternoon and it was clear they had walked from their chair to their bed with a blanket around their ankles, which would have increased the risk of them falling. Had they fallen staff would have no way of knowing this had happened until they had reason to go to the person's room.

We observed another person was being supported with their mobility at lunchtime by two staff. Although the support and encouragement was provided appropriately, it placed the person at risk of sustaining a fall. The person was being assisted to sit in an area which had limited space and did not have room for staff to walk safely with the person. The person had to squeeze past another person who was sat at the dining table in a wheelchair. At one point the person held onto the wheelchair to take a rest and both staff had to lean across the person sat in the wheelchair to support the other person. This created an unnecessary risk to both people, and the person being supported was more likely to fall because staff were restricted in the support they could provide. This also posed a risk the person could fall onto the person who was sat in the wheelchair.

People were living in an environment which was being maintained. Maintenance records showed routine checks and tests were, with a few exceptions, carried out at the required frequency, although the column to show the date these were carried out was not completed. There were systems in place to assess the safety of the service such as fire risk and the risks of legionella. Staff had been trained in relation to health and safety and how to respond if there was a fire in the service. Staff spoke of carrying out visual checks each time they used the equipment to ensure it was in good working order.

People lived in a service where the risk of abuse was minimised. People we spoke with told us they felt safe. One person told us, "It's a safe place for me. Not an aggressive place." Relatives also said they felt their relation was safe with one saying, "It is absolutely safe here" and another saying, "Very safe place. We'd score it 9.5/10 for safety."

People were supported by staff who recognised the signs of potential abuse and how escalate concerns they had about people who used the service. Staff had received training in recognising the signs of abuse and how to report concerns. Staff were able to describe the different types of abuse and harm people could face, and how these could occur and said they would report any concerns they had to a senior member of staff. They felt that any concerns they did raise would be acted upon.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. The provider told us in the PIR that they operated a robust and regularly updated recruitment policy. We saw this included acquiring references to show the applicants suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions. Checks had been completed to ensure nurses employed had kept their registration up to date. The registered manager told us one nurse had let their registration slip, but they had corrected this when it was brought to their attention. Staff described having undergone the required recruitment process and recruitment files showed the necessary recruitment checks had been carried out.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. People we spoke with told us that staff gave them their medicines when they were supposed to. The relatives we spoke with told us they had no concerns about medicines management in the service.

We found the medicines systems were organised and that people were receiving their medicines when they should. Staff were following safe protocols in relation to the receipt, storage and handling of medicines. Staff had received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines. Care staff said they did not administer medicines, this was done by nurses and senior staff. Staff told us they felt the medicines were managed safely.

Requires Improvement

# Is the service effective?

## Our findings

People were not always supported to eat and drink enough. We spoke with people about the food and they told us they thought the food was very good. However we observed that people who needed support to eat their meal were not always supported in in line with instructions in their care plan.

We saw staff supported some people with their meal at lunchtime, where this was needed. However this was not consistent with people who needed support to eat and drink, and the meal time was not as social an occasion as it could have been. We observed one person who struggled to hold the cutlery and get near their meal. On two occasions the person gave up trying to eat and was pushing the food away in frustration. Eventually, after a period of 20 minutes, the person managed to get some food onto the fork and into their mouth, however they were unable to break the food down to smaller pieces and so was eating quite large pieces of food. The person had an adapted cup and straw due to difficulties with drinking and we saw they were struggling to turn the cup around so they could get a drink. We suggested to staff that the person would benefit from some help and this was then given. We observed times when there were no staff available in the dining room and for a large part of the meal staff appeared task driven and very busy.

On the morning of our arrival we saw one person who was struggling to get food into their mouth and had spilled most of it down their front. This was not responded to by staff and when we asked them why, they told us the person could "get aggressive if we try to help." However staff did not attempt to offer support to the person and see if they would accept it and this person's care plan stated they did need help to eat their meals as they were very underweight. The same happened on the second day of our visit when again this person was left without support and again spilled most of their meal on their front and were not offered any assistance with eating or to clean the spilt food.

People who relied on staff to support them to eat did not always receive the support they needed. Records showed that one person was at risk of malnutrition and was underweight. We checked the food records for this person and they showed that the person had gone without anything to eat for 17 hours on the day prior to our visit as staff had recorded, 'refused' on their care chart. Staff had not recorded any attempts to go back later in the day to try and prompt the person to have something to eat. We had similar concerns about this person's nutritional support on the first and second day of our visit.

Additionally records showed that on some occasions staff had recorded the person had eaten their meal, however they didn't specify how much had been offered. We observed this person during our visit and although their care plan stated they should be supported with nutrition at 12:30, they were not offered anything to eat until 1.50pm at which point they were asleep. We raised this with the registered manager and staff returned to support the person to eat at 2:30pm. A further person's care plan stated they needed to be supported with their nutrition at 12.15pm, however we saw the person had not been given their meal at 1.30pm. They were supported to eat shortly after that.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, people we spoke with, who could eat independently, told us they felt the food was good, although two people said there was not always a choice. One person said they were, "Never hungry. I get snacks when I want them. I try to eat less and walk more to keep active." Another person said, "Very good food. I don't really get a choice. I get lots of fluids and if I'm not well then other foods are offered. It's a 100% better than the previous place." One relative told us, "[Relation] has enough to eat. [Relation] mostly likes the food and gets enough to drink. The food is pureed. The staff also give me a meal."

We observed that when people had a special diet such as pureed or soft diets then these were provided. We also observed people were provided with snacks if they were feeling unwell or had a poor appetite. There was a list in the kitchen listing how people needed to receive their nutritional support. We did note that this list had not been completed for one person and another person we observed at lunch time did not have their drink given in the way described as their preference on the list. The cook told us they were responsible for completing the list which they did from the electronic system used for planning care. Staff spoke of feeling confident in supporting people with their nutrition and also told us they ensured there were drinks available throughout the day in communal areas and in people's rooms. There was also a water dispenser people could use if they wished.

People told us they felt that staff were trained to support them safely, however, information we received and some of our observations raised concerns about staff knowledge in some areas of care delivery. Staff we spoke with told us they had been given training in some aspects of safe care delivery to ensure they knew how to do their job safely. They told us they felt there needed to be more training in relation to supporting the individual needs of people such as people who were receiving end of life care and people who lived with the dementia related illness. Staff also said they would like more information about health conditions people had. One long standing staff member said they had been given some training about some specific health needs one person had so they knew how to support the person in certain circumstances, however more recently appointed staff hadn't been provided with this training and they said they would not know how to support this person in these circumstances. We saw records which showed that staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and infection control.

People told us they were supported to make decisions about areas of their care and support. One person told us, "You can do it or not do it. I am not pressured by anyone. I am selective about what I want to do. I can get up and sleep when I want. I can have meals in my room if I am not feeling well."

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.

Staff spoke of respecting people's rights to make their own decisions and of obtaining their consent before providing them with any care or support. They knew about the process of assessing a person's capacity to determine if they could not make a specific decision. We found that MCA assessments had been undertaken for people who lacked the capacity to make decisions about aspects of their care and support such as the use of bed rails and medicine management. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made which ensured that the principles of the MCA were followed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had developed a system to assess if people may be being deprived of their liberty and had made a number of referrals to the local authority for this to be assessed formally and was waiting for their response.

People were cared for by staff who received feedback from the management team on how well they were performing and to discuss their development needs. Staff told us they had supervision from the registered manager or nurses and were given feedback on their performance and we saw records which confirmed this. Staff records showed that they had not all been kept up to date with their supervision and appraisals, although these also showed that the new registered manger was addressing this and staff were "catching up" in all of these areas. The registered manager explained how they were doing this and when they expected staff to be fully up to date.

People told us they were able to see the GP if they were unwell. One person told us, "The GP comes twice a week. I have never needed him but could see him if I wanted. I see an optician and my [relation] takes me there." A visiting GP commented positively on the care people were given and told us, "It is good. I would put my parents here."

Staff spoke of supporting people to see the GP or attending appointments for healthcare. They told us they would accompany people to appointments if their relatives were unable to do so. Records showed that people were supported to see the GP when they were unwell and that people had access to a chiropodist and opticians. Records showed people were supported to access health appointments and that staff made referrals to external health professionals if they needed advice.

Inadequate

# Is the service caring?

## Our findings

The service offered an 'enhanced' provision of retaining two beds for people who were discharged from hospital on end of life care. These were commissioned by the Clinical Commissioning Group on behalf of the NHS Trust.

We looked at the end of life care one person was receiving, who was not in an enhanced bed, and we had significant concerns about the lack of pain management the person was given despite having a health condition which caused the person substantial pain. The nurses were carrying out unnecessary interventions rather than carrying out an assessment of what interventions were actually needed in the person's final few days. We also had concerns about the general care this person was receiving in relation to mouth care and ensuring they were as comfortable as possible at this time. We had to intervene and instruct nursing staff on providing the person with the appropriate pain relief which they had already been prescribed, and we ensured this was followed through.

We looked at the care plan in place for this person and another person who was in one of the enhanced beds, and we found there was a lack of care planning in place to guide nurses and staff in how to support both people and ensure they were given appropriate care and support. There were no systems being used to assess and manage symptoms such as pain or mouth care. This meant we could not be assured that people would be supported to end their lives free from pain and with dignity. We found there was a lack of knowledge from nursing and care staff in how to appropriately support people who were near the end of their life.

This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us in the PIR that they identified, planned and promoted person centred care including emotional, spiritual, friendships and social interaction. However our findings did not support these claims. Although people told us they felt they were given choices about what they ate and how they spent their day, we observed this was not always the case. We observed part of the mid-morning drinks round were people where people had a hot drink and snack, such as biscuits, flapjack or a choice of soft mousse. We saw that this was not done in a way to involve people in conversation or to provide people with choice. On most occasions the snack was selected by the staff member without asking what the person wanted. This included not asking people who required a soft diet which of the two flavours of mousse they would prefer.

Some people who used the service lived with a dementia related illness but recognised best practices in creating a 'dementia friendly' environment had not been utilised. The environment did not lend itself to supporting people with a dementia related condition to orientate themselves. The corridors were all decorated the same and there was a lack of signage or colour coding which would help people know where they were or support them to find their way to their bedroom or to the toilet and other communal areas. We found it difficult to find our way around the service and one member of staff said, "It took me two months of working here before I could find my way around."

The service lacked a person centred approach to care and support. People had their name on their bedroom doors, however this was in small print and there was a lack of any meaningful images that would make it easier for people living with a dementia related condition to recognise their bedroom.

Staff were not always responsive to people's needs and did not always know people's preferences. We observed one occasion where a person was given a drink and they were unable to hold the drink due to a health condition. They asked the catering staff for support with the drink and the catering staff member said they would find a member of the care staff, however this did not happen and the person did not get the support. Additionally we observed the person had asked for coffee and got tea which they told us they disliked. Staff said the registered manager found out information about what care and support people wanted as part of their initial assessment and whether they had any particular likes or dislikes. However there was a lack of detailed information about people's likes, dislikes and preferences for care detailed in people's care plans. The information available to staff relating to people's life history and what they had achieved in their life was also very sparse.

We observed that some staff displayed a kind and caring attitude to their work when supporting people but this was not consistent throughout the staff group. One person told us, "Some (staff) are very good (at caring) and others less so." We reported concerns to the registered manager about our observations of the attitude of some staff and the lack of compassion one person was receiving. One visiting health professional also told us that they didn't feel that some nurses were as caring as they should be.

Staff spoke of the importance they placed on respecting people and getting to know them well. They described occasions when they did have some time to sit and talk with people, but said there were other times they did not. We noted that there were opportunities when staff could have made some time to speak with people but did not do so, and other occasions when they did. We discussed this with the registered manager who agreed this happened and said they had already identified as a task to address was to spend some time 'working the floor' to give guidance on effective shift management.

There were missed opportunities for staff to engage and socialise with people who used the service. There was entertainment in the service in the afternoon with a visiting school choir performing as part of the Christmas festivities. However there was only an administrator present in the room at first and they were later joined by the activities co-ordinator. Care staff were not present to encourage people to participate in the festivities and to make it a social occasion.

Despite this, people who used the service and their relations spoke very positively about the caring nature, friendliness and gentleness of staff. One relative expressed considerable gratitude for how the staff were supporting their relation and themselves through an emotionally and physically difficult time in their lives. One person told us, "They pull my leg and I pull theirs." Another said, "They (staff) are very good." A relative told us, "I have never seen anything other than decent, kind, loving behaviour. As if it was one of their own." Another relative told us, "[There is] Lots of loving care." A third said, "Staff are good with [relation]. They're gentle and friendly."

People were supported with their religious preferences. One person described having a strong faith and told us they were supported with fortnightly communion and to listen to faith music and to songs of praise. Their relative agreed with what the person told us and said staff supported their relation with this and had "found out what stimulates [relation]."

Positive relationships had been developed between care staff and people who used the service. We heard a member of staff thank one person for their Christmas card and the person thank the member of staff in

return. Staff spoke of enjoying their work and the pleasure they got from making a difference for people. They said it was rewarding seeing people smile and knowing they were happy. Staff said they provided a caring environment through good team work and effective communication. One relative told us, "They are a devoted group and show great care."

There was work underway to improve the environment with some areas having been decorated and others in the process of being done. Carpet fitters were working laying carpets in a number of people's bedrooms. People had been involved in choosing their carpets and colour schemes to ensure they felt comfortable and at home in their bedrooms. We also noted that attention was given to making a homely atmosphere, for example the dining room tables were all nicely laid out in preparation for the next meal. There were seasonal decorations around the home which created an appropriate festive atmosphere. An activities coordinator told us they were having a festive fair at the weekend and had decorated the home in preparation for this.

People were generally supported to have their privacy and were treated with dignity. One relative told us, "When I come to visit they (staff) leave us alone. Privacy is respected. My [relation] trusts the staff including the young men." Another relative told us, "[Relation] is totally dependent. Staff always close the door and knock on the door. We are asked to leave the room for his privacy [when personal care is given]. Staff speak in low tones and don't use loud voices." Two people were having their lunch in one of the small lounges, and they told us they had only recently started to do so. They were pleased with this arrangement and said prior to this their mealtime arrangements had not promoted their dignity.

We observed staff knocked on doors before going in to people's bedrooms they ensured doors were closed when taking people for a bath or to the toilet. Staff ensured people were able to have visits from their relations in private if they wished. Staff told us they were given training in privacy and dignity values as part of their induction and staff we spoke with were able to describe how they would respect people's privacy and dignity.

Requires Improvement

# Is the service responsive?

## Our findings

People's care and support was not assessed or planned for appropriately. The provider had an electronic care planning system in place and although we saw there were benefits to this system we found that this resulted in a lack of personalised care planning for people who used the service. We looked at the information staff had access to on the electronic system about people's needs. This was limited and was not person centred. Much of the information was produced with a pre-determined response on the basis of other data that had been entered. For example we found one person who was in a lot of pain and staff had recorded on the electronic system that the person had grimaced in pain when they tried to move them and so they had left them without moving them. The electronic system had pre-populated text and the following line stated the person was 'overall content.' It was clear from records and from observations of the person they were far from content and so the wording was inappropriate and not person centred.

Staff could see some benefits from the electronic care plan used, such as prompting when someone needed to be supported to protect their skin integrity by being repositioned regularly throughout the day. However they also felt there were occasions when they were too prescriptive and they felt pressure due to the number of tasks that needed to be completed at the same time. There were alerts generated on the system if the times for these tasks had lapsed and the care had not been given as planned. However we saw this system was not yet working in a way which would respond to people's needs and on all of the care records we saw, there were alerts flagged stating that staff had missed the timescales for tasks. The registered manager told us this was due to staff not yet knowing how to record information correctly as they were still getting used to the system. This posed a risk as it was impossible to determine if some tasks had been completed and people had received their care as planned.

Staff did agree that it was still 'early days' in using these and they would like more training on them. The registered manager told us they had phases of training planned as staff became more familiar with them and the next phase of training was ready to be provided.

People's needs were not appropriately assessed or planned for and this had an impact on their health and wellbeing. One person had a chronic health condition and had recently been hospitalised due to complications with this health condition. Their relative described how this had severely impacted on their relation's health. We looked at this person's care plan and the health condition was not mentioned at all and so there was no guidance for staff to follow to recognise this person's condition was deteriorating or how to monitor it. This had an impact on the staff ability to recognise when things were going wrong for the person and earlier nursing intervention sought.

We found issues with the care records for other people who used the service which contained brief detail about their conditions and their support needs. In many cases the information was inconsistent or not recorded at all. For example one person had been assessed as being at high risk of developing a pressure ulcer. There was a brief care plan in place which stated the person needed support from staff to reposition and alleviate the pressure on their skin but did not specify how often this should happen. However their care records showed the repositioning was not being carried out. We spoke with the registered manager about

this and she said she didn't think the person needed support to reposition and was surprised to see this entry in their care plan. This person was also left sitting on a sling all day which would increase their risk of developing a pressure ulcer. Their care plan stated they sat on the sling during the day but there was no risk assessment in place for this.

One person had a health condition which left them at risk of suffering seizures. There was no care plan in place detailing what type of seizures the person had, how staff would recognise they were having one or what action to take if a seizure occurred. The person also had diabetes and again there was a lack of care planning detailing how this needed to be monitored and managed by staff. This meant staff did not have appropriate information about people's needs to guide them in supporting people safely.

One person's care summary also stated the person was at risk of displaying challenging behaviour and resisting care when it was offered from staff. There was no risk assessment in relation to this and no care plan informing staff of how they should support the person if they resisted personal care, other than a note saying staff should leave the person and go back later and try again. There was no information guiding staff on diversion techniques they could use to support the person in receiving their personal care.

This was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a Closed Circuit Television system (CCTV) installed throughout all communal areas of the service. Some people lived with a dementia related illness and so may not have the capacity to understand that they were being recorded. This had not been considered as part of consultation when the CCTV was installed. When the system was installed the provider told us he had informed all of the people who used the service and their relatives. However we found that people had not been consulted appropriately and neither had some of their relatives. We spoke with three relatives who were visiting and they were surprised to hear they were being recorded. Two people who used the service told us they were unaware there were cameras recording them. There was signage in place outside the service informing people there was CCTV in operation, however this was inadequate in ensuring people understood where and when they were being recorded. The signage was not clear in informing people it the CCTV was in operation inside the service as well as outside. Additionally it did not inform people why the CCTV was being used.

We looked at the information given to people and their relatives when they were deciding if they wished to move into the service and the information given upon admission and none of this specified CCTV was being used in the service. This meant there was a risk people would not know about being recorded when they made the decision that this was the right care service for them. When staff decided to work in the service there was no evidence they were informed of the CCTV being used. The provider had a policy in place for the CCTV but this was not a robust policy and additionally was not being followed in practice.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they were consulted in relation to other areas of planning and making choices about their care and support. One person told us, "My relatives visit on weekends. We have a care plan and it is renewed every so often. Alterations are made." A relative told us, "I'm consulted every step of the way on changes in regime and our opinions are sought including any concerns." Another relative told us, "We have been consulted throughout" and "[Relation]'s wishes are respected." A third said, "I have seen the care plan and staff ask me about [relation]'s needs."

People were given the opportunity to take part in activities and to socialise. One person told us, "I was a pianist. There is lots of music here. I play for people once a month. The boss will get me any music sheets I want." This person added, "We did craft activities in the morning and make things that are sold to support activities here. There is so much going on in December." A relative described their relation as becoming socially isolated prior to moving into the service and told us, "They have involved [relation] in activities and brought [relation] out."

A programme of activities was displayed on the notice board and two activities co-ordinators were working in the service. During the morning, a craft workshop was observed with six people who used the service in the dining area and after lunch a carol session took place. Both sessions were clearly enjoyed by people with people looking happy and smiling. The activities were available in groups and individuals would get 1:1 work in their rooms. The activities co-ordinator showed how their interventions were recorded on the I-pads onto person's case notes.

We observed the activity organiser doing some arts and crafts with a group of people who used the service in the afternoon. People were engaged in this and were having a conversation about forthcoming activities. The activity organiser reminded people they were going to a nativity at the weekend and that when they arrived back they were going to be making Christmas tree decorations. They discussed the regular bingo session which was going to be held and one person said they thought "[person who used the service] was the best bingo caller."

People we spoke with told us they had not had to raise a complaint but said that when issues of their needs were discussed with staff then they were acted upon quickly. One person told us, "If I needed anything or was unhappy I would talk with carers and they would take it to the manager. No one's prevented from saying what they want or afraid that there would be any reprisals. It's very good." Another person told us, "If I was unhappy with the care I would raise it with the team leader or the manager. I'm not really aware of the complaints procedure. The issue has not arisen. I am quite capable of speaking up for myself." Relatives we spoke with also said they felt their concerns would be listened to. One told us, I would have no hesitation in going to the manager with concerns or complaints. I mentioned the slow electric kettle in the lounge and in 48 hours the boss had replaced it." Another relative told us, "If we needed to complain we would go to the head of nursing or the manager."

We saw there was one written complaint recorded in the complaints log. This had been investigated appropriately by the registered manager and the person making the complaint received an apology and details of what actions had been taken to minimise the risk of any further complaints of this nature.

Inadequate

# Is the service well-led?

## Our findings

We found there had not been a culture of shaping the service around the needs and preferences of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding breaches in regulation and negative outcomes for some people who used the service. Although new systems had been implemented to develop and improve the service, these were in their infancy and had not identified the issues we found. The systems that had been relied on prior to the new systems being implemented had been ineffective in monitoring, identifying issues and bringing about improvements.

During our visit we had concerns about the lack of leadership and skills of some of the nurses and how this was impacting on the care and support people received. We have reported on this impact in the safe and caring sections of this report. There was a new registered manager in post and she was clear about her responsibilities under the Health and Social Care Act 2008. However the service was large and due to the layout the registered manager needed support from the qualified nurses employed in overseeing staff and leading them to ensure people received appropriate care and support. We found that this was not always happening and this was impacting on the care people were receiving. Although there was a high number of staff on duty to support people, some people were not always receiving the care and support they should.

We spoke with a visiting professional about the nursing staff and they told us that some of the nurses were resistant to changes and recommendations made to them. They also said that some of the nursing staff lacked the knowledge and confidence to make decisions and implement changes.

In the months leading up to our inspection we received a high number of concerns about the care people were receiving in the service and significant concerns about the staffing levels in the service impacting on the care people received. The registered manager who had been in post for a short period of time told us this was recognised as soon as she started working in the service and as a priority she had recruited more nursing and care staff to address this. We saw that staffing numbers had doubled since February 2016. Records of meetings held in the service showed that relatives had raised concerns about staffing levels and the significant impact this was having on people who used the service with very poor levels of care being reported in February 2016. It is of concern that the staffing levels and poor levels of care had to be pointed out to the registered provider by relatives.

Prior to the new registered manager starting in post there had not been a registered manager in post since January 2015 and so the provider had sole legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We found at this inspection that the provider was not meeting the regulations and it was clear from speaking with the provider that had we visited some months sooner we would have found more significant concerns. Despite a number of relatives raising concerns about the care of their relation since February 2016 and the local authority raising concerns about the lack of person centred care planning, a lack of quality monitoring of the service and inadequate staffing levels in March 2016, any changes made by the provider in relation to person centred care planning, staff deployment and monitoring the quality of the service were ineffective.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not live in a service which was open and inclusive. A live stream of the CCTV in operation in the service was able to be accessed by the provider and registered manager when they were at home. There had not been an appropriate consultation in relation to this, to ensre people knew why they were being filmed, or what the recording policy was. Additionally some staff told us they had not been made aware of the CCTV operation during their interview. Staff spoke of occasions when they had been directed to carry out tasks whilst they were spending time involved in conversations with people. They told us that they suspected that this happened when they had been seen on CCTV sat talking with people. This led them to feel uncomfortable when they spent time engaging with people in conversation rather than carrying out more practical care tasks.

Staff made a number of positive comments about how the new registered manager had gone about making changes in the service. However they also mentioned a few areas they were not comfortable about. They felt there was not a united approach between management and nursing staff. When speaking with staff it was evident that some staff were apprehensive at speaking openly about their views.

People we spoke with told us they knew the new registered manager and felt she was a positive change. They expressed confidence in her and descried her as approachable, saying there was now an open door policy. People felt the service to be better led than before. One relative told us, "The new manager is top class. She is courteous and, penetrating and very skilful in what she is doing. Has her fingers on the pulse. She has made our [relation]'s transition easy." Some people we spoke with commented that the new registered manager "keeps them (staff) on their toes." One added, "It was needed." We were given examples where people had been left waiting for support for long periods of time. We found the registered manager was clear about their responsibilities and they had notified us of significant events in the service.

The new registered manager had improved the meetings held for people who used the service and their relatives. Records showed she was implementing changes based on what relatives were suggesting and relatives told us this was the case. One relative told us, "We have quite a new manager. I can raise any concerns with her. At the residents meeting we asked for waste bins and the manager got bins for all the lounges." Another relative told us, "There was a residents meeting about 3 months ago. Little issues were taken on board." A third relative described giving their views about how their relation's care could improve and told us this had been acted on. They told us, "Our experience was listened to." The registered manager told us she was improving and implementing a new system for capturing people's views of the service through a new satisfaction survey.

The registered manager showed us the systems they were putting into place to identify where improvements could be made to people's care and how the service performed. These included analysing the circumstances around any falls people had to see if action could be taken to prevent any further falls and monitoring people's weight to see if they needed to respond to any change in this. There was a system followed to audit the management of medicines and we saw action plans had been made to bring about improvements that had been identified. These actions had then been recorded as completed and these were found to have been so in a later audit carried out by a pharmacist.

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<br><br>Regulation 9 (1) (a)(b) and (3) (b)(c)(d) |

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<br><br>Care and treatment was not always being provided in a safe way for service users. Regulation 12 (1)(2)(a)(b) |

**The enforcement action we took:**

We served a warning notice

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity were not effective. Regulation 17 (1)(2)(a)(b) |

**The enforcement action we took:**

We served a warning notice