Avery Homes RH Limited

Aran Court Care Centre

Inspection report

Braymoor Road
Garretts Green
Birmingham
West Midlands
B33 0LR

Tel: 01217704322

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 and 24 November 2016 and was unannounced.

We last carried out a full inspection of this service on 02 September 2015 when we identified that improvements were needed in two of the questions we ask; Is the service safe and Is the service well led. We carried out a focussed inspection on 09 March 2016 following a serious incident in the home to assure ourselves that people were safe and following that inspection we felt assured that people were safe. At this inspection we checked that the required improvements had been made and maintained. We saw that although some improvements had been there were issues that that meant that further improvements were needed to ensure that people received good quality care.

Aran Court Care Centre provides nursing and personal care to up to 86 people for reasons of frailty, physical disability, sensory impairment and mental health disorder.

The registered provider is required as part of their conditions of registration to have a registered manager in post. At the time of or inspection there was a registered manager in post but they had only been in post for a few weeks. 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.

We saw that some improvements were needed to the management of medicines to ensure that people received their medicines as prescribed. We identified this as a breach of regulation.

During our inspection some people and their relatives and staff expressed their concerns regarding the staffing levels in the home and the high dependency on agency staff. People felt that on occasions there were insufficient staff available to meet people's needs. The provider had assessed the number of staff needed to meet people's needs but due to the dependency on agency staff to meet the required numbers because of a high turnover of staff people were unhappy with the number of different people in the home who did not know their needs. Some efforts were being made to meet the social needs of people but these were limited as there were no specific staff with responsibility for this area of need.

People's needs were met but care provided to people was generally task orientated rather than person centred. For example, staff completed basic tasks for people such as assisting with personal care and ensured that they received pressure relieving equipment to prevent skin damage. However, staff did not always ensure that drinks and emergency buzzers were always accessible to people to ensure that their hydration levels were maintained and they were able to summon assistance if they needed it. Information received during and after our inspection showed that people's continence needs were not always being adequately met.

People received food and drink that met their nutritional needs but mealtimes were not always a pleasant experience and well managed, particularly for people living with dementia.

Staff were supported to provide care to people through the provision of training, supervision and through meetings and handovers.

Systems were in place to listen to the views of people and take actions to address the issues raised through complaints, surveys and meetings. The quality of the service was monitored but the systems had not always identified areas for improvement and plans put in place to monitor and sustain improvements.

Systems were in place to ensure that people were given choices and consent obtained for the care and treatment they received.

You can see what action we told the provider to take at the back of the full version of the report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected from abuse because staff were able to recognise the signs of abuse and able to raise any concerns they had.

Systems were in place to identify and manage risks associated with people's care.

There was not a stable staff team in place so that people received continuity of care.

People generally received their medicines as prescribed but some improvements were needed to the management of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received care to meet their day to day needs and were encouraged to be involved in making decisions about their care. Were needed staff would make decision in their best interest.

Systems were in place to ensure that people's liberty was not restricted without the appropriate authorisations.

People's dietary needs were met but mealtimes could be better managed to offer a safer and more social event.

People were able to receive medical attention when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were complimentary about most staff but there were occasions when people felt staffs attitude and language was not always caring.

People's privacy and dignity was not always promoted by staff on behalf of people with limited abilities to raise issues.

People were supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care that was personalised to meet their needs.

People were able to raise concerns and express their views about the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There had been a change in registered manager and staff felt that during this period there had been a lack of support and staff did not feel confident that their views and concerns were being listened.

There were some audits being undertaken and quality measures being recorded but the systems were not robust enough to identify the actions to be taken and how they were being monitored to ensure improvements were made and sustained.

Aran Court Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 14 and 24 November 2016.

The inspection was carried out by three inspectors and two experts 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. Our experts-by experience had experience of using this type of service.

Before our inspection we looked at the information we hold about the service including notifications and concerns we had received. Before this inspection we had received concerns about staffing levels, a high use of agency staff and some aspects of the care provided in the home. Notifications are incidents that occur in the home such as injuries or safeguarding concerns that the registered provider has a legal duty to tell us about.

We had asked the registered provider to complete and return the Provider Information Return (PIR) which we had received and used to inform our inspection. The PIR is a form that asked the provider to give some key information about the service, what the services does well and improvements they plan to make. We reviewed regular quality reports sent to us by the local authority that purchases care on behalf of people, to see what information they held about the service. These are reports that tell us if the local authority has concerns about the service they purchase services from on behalf of people. We also contacted the Clinical Commissioning Group that purchased services on behalf of people.

We observed how staff supported people throughout the inspection to help us understand their experience of living at the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We spoke with 28 people that lived in the home, nine relatives, and 11 staff including those with

responsibility for care, nursing and management of the home. We looked at seven people's care records to check if they were receiving care as planned. We looked at records including staff training records, complaints records and records relating to the monitoring of the quality of the service. We looked at medicine management processes to determine if people received their medicines as prescribed.

Requires Improvement

Is the service safe?

Our findings

Most people told us that they received their medicines as prescribed. We saw that a nurse offered tablets and a drink to one person and waited to check that the medicines had been swallowed before signing the medicines administration record (MAR). Staff told us that only nurses or senior care staff who had received training were able to give medicines to people.

Our inspection showed that some aspects of the management of medicines needed improvements. We saw that the MARs did not always accurately reflect the medicines people had taken. For example, we saw that one person could be given half a tablet of a medicine to manage their behaviour and we compared the MARs with the tablets remaining in the trolley we saw that half a tablet was unaccounted. For another person a medicine had been discontinued however the MARs had been signed twice since that time to say the medicine had been administered although the medication was not available at the time of our inspection.

During the second day of our inspection one person told us that they had not had some medication they were to have on a daily basis for several days. When we checked the medicine administration record (MAR) we saw that only 10 days' supply of this medicine had been received at the beginning of the medication cycle and there was no evidence that this had been followed up the before the supplies ran out to ensure it remained available. At the time of our inspection the medicine had not been available for five days. We saw that a new prescription had been received the previous day but had not been collected at the time of our inspection. For another person we saw that although some painkillers were identified as available on the MAR they were not available on the trolleys or in the cupboards. This meant that people may not have access to pain relief when they needed it.

During our inspection we saw that lockable medicines trollies were available and these were usually kept in the treatment room. However, during our inspection we saw that medicines were not always kept securely. We saw that the keys were left in two medicine trollies whilst the treatment door was wedged open and accessible to ancillary staff undertaking their duties in the vicinity. Before our inspection we had received a concern from a relative that a nurse had left the medicines cabinet keys on their relative's bed for over an hour before they realised and came back to retrieve them. We saw that one tablet to be given in the evening had been taken out from the blister packs in error in the morning and placed in a medicine tot in the trolley with the name of the person it should be given to and the time for it to be given. This showed that medicine practices were not always safe and staff had not followed the providers policies

We looked at the MARs for eight people and checked the protocols for some 'as and when required' (PRN) medicines. We saw that there were protocols in place for when PRN medicines were to be given. We saw that PRN protocols contained information about the maximum amount of medicine that could be given in a 24 hour period. The symptoms that could lead to this medicine being given were identified but there was a lack of consistency in the level of details in the description of the triggers for when these medicines should be given. For one person the symptoms included; 'agitation, anxiety and restfulness' which gave little information about the person's presentation. For another person the symptoms were described as 'facial

grimacing and tense body' which helped PRN medicines to be used consistently. Although the staff we spoke with knew when these medicines should be given it was important for a good description of the symptoms to be recorded particularly as there were a number of agency staff that worked in the home who may not know people well.

We saw that MARs were being inconsistently completed. For example, where people had refused a PRN medicine some MARs showed a gap whilst others showed the use of the code denoting that the medicine had been offered but refused. We saw that where discrepancies were occurring in the records they were not being queried and addressed in a timely manner.

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

The Clinical Commissioning Group (CCG) had also identified improvements that were needed in the management of medicines. The registered manager told us and we saw that an action plan had been put in place to address the issues raised by the CCG.

Comments from people indicated that they felt safe most of the time but there were times when they didn't feel safe. One person told us, "I do feel safe but don't when they move me in the hoist." Another person said, "Yes I feel safe, I can lock both my outer and inner doors, and the main door is secure." Staff were able to tell us what actions they would take if they felt people were not safe from abuse and told us they had received training in safeguarding. Training records confirmed that staff had received training on how to keep people safe. Records that we hold about the service showed that the appropriate authorities were notified so that issues could be investigated and monitored.

The Provider Information Return (PIR)told us and staff confirmed that the appropriate recruitment checks were undertaken to ensure that as far as possible only suitable staff were employed. The PIR said all staff completed a DBS and at least two references were obtained. Staff confirmed that they had had a Disclosure and Barring Service (DBS) check and provided the names of two referees so that references could be obtained from previous employers. The DBS assists registered managers and providers to make good recruitment decisions.

Risk associated with people's needs had been assessed and management plans were in place. For example, the potential for skin damage for people with reduced mobility had been identified and we saw that plans had been put in place for people to be repositioned at regular intervals if they spent large amounts of time in bed. We saw that people at risk of falling out of bed had bedrails in place where needed or had their beds lowered and mats put on the floor by the side of their bed to prevent injury as far as possible if the use of bed rails was not appropriate. We saw that one person who had been identified as being at risk of falls did not have a plan in place to inform staff how the risk was to be managed. A head injury had been sustained for this person and no medical intervention was sought and the person was not monitored following the injury. This could have left the individual at risk of a potentially undiagnosed injury.

Systems were in place to keep people safe in emergency situations. We saw that equipment was being regularly maintained to ensure that it was safe for use. Staff confirmed that regular checks were made on equipment such as hoists and slings.

Following a significant incident the provider had reviewed their We saw that all staff were told about the emergency procedures such accessing an external telephone line when ringing for an ambulance and how to use the emergency buzzer. Staff told us and training records showed that all staff received training in fire

safety and the action to be taken in the event of a fire so that staff knew what actions to take in the event of a fire. Some staff had undertaken emergency first aid at work so first aid could be provided if needed and the provider had a plan in place to ensure that this training was kept up to date.

People and staff did not always feel that there was sufficient staff available to meet people's needs and felt that there were often agency staff on duty that did not know people's needs. People told us that they were bored and lacked stimulation and we saw that there were no staff whose specific remit was to provide activities and stimulation to people. One person who was not taken to see the singers that came into the home during our inspection expressed their disappointment at missing the singers as the staff had not got them washed and dressed in time. This was at 11.20am. The provider told us that this was because dressings had to be done and this had caused the delay.

One person told us, "There are a lot of strange faces; I'm a bit fed up really." Some relatives told us that there had been a staff shortage a few days before our inspection. One person living in the home told us, "Saturday first thing there were only two staff on; no there isn't enough staff. I need support when going out, but they don't have enough staff. I have to rely on a friend. I have spoken to management and they have said they will sort this out." A relative also reported this incident to us as well as a generalised shortage of staff. During discussion with the registered manager we learnt that two staff had rung in sick on that day and they had arranged for agency staff to fill the shortfall later in the morning. The registered provider told us that agency staff were organised as soon as staff had rung in sick and they could evidence there were sufficient staff on duty but some people and relatives did not consider agency staff as part of the staffing structure.

During lunchtime we saw that on one unit there was insufficient staff to adequately manage and support people. This was partly due to the fact that an agency staff member left the unit without informing anyone, but also because staff brought from another unit to cover the shortfall did not ensure that there was adequate supervision. As a result we saw that one person who was supposed to be on close observations was helping themselves to from the hot trolley. One staff told us that the lunch time situation (during our inspection) was not as bad as it usually was. The registered provider told us there had been some staff turnover, and sickness had been an issue meaning that there was a higher dependency on agency staff than usual in the home. The PIR told us that "Staffing levels are assessed in line with dependency. Weekly hours are analysed against appropriate staffing" however, comments from staff, people, relatives and our observations showed that people's needs were not being met appropriately at all times.

Requires Improvement

Is the service effective?

Our findings

People told us that their needs were generally met but there were some concerns regarding the care provided by some agency staff who did not know their needs. For example, one relative said, "The majority of staff are brilliant, but at the weekend an agency carer thought my [relative] could drink independently and gave [relative] a drink which they spilt all over themselves." During our inspection we saw one agency staff did not know whether they could assist a person to eat their breakfast and turned to us to ask if they could assist them.

People did not always feel that the care provided was effective. One relative said, "The staff are very pushed, my [relative's] hygiene can sometimes be poor. My daughter visited at the weekend and was concerned that oral hygiene had not been carried out all week." Before our inspection we had received some concerns from families about the care people had received. These concerns were about a lack of expertise by the staff in caring for people with some specific medical conditions, management of equipment such as catheters; and drinks being left out of reach and people not being supported to eat and drink. We had received concerns from a local hospital that some people sent to hospital were not being accepted back into the home and this was unfair to people who were not aware they would not be returning to the home although their needs had not changed significantly. We discussed this with the provider who told us that the need for some people to be reassessed had been raised with the authorities with responsibility for placements and families about a need for reassessment so that some individuals needs could be met appropriately.

People and relatives were very positive about the support they received from the regular staff who they felt knew their needs wells. Staff told us that they felt that they received training to support them in carrying out their roles. One staff told us that they had received induction training and had shadowed more experience staff before they started work. Another member of staff told us that they had undertaken a lot of training over recent weeks. This included training in basic life support and dementia awareness. Training records showed that the registered provider had a programme of training for core training. This included induction training, infection control, fire safety, food hygiene, safeguarding and moving and assisting people. Some staff undertook training in emergency first aid at work and medicine competence. The Provider Information Request (PIR) told us that some staff had completed the Care Certificate. A member of staff told us that they thought they were working towards the Care Certificate qualification. This is a qualification that when completed should ensure staff have the required skills and knowledge to provide good care. Staff told us that they received support to carry out their roles through staff supervisions, attending staff meetings and appraisals.

Care plans were in place to provide staff with information about how to meet people's specific needs such as diet, preventing skin damage and mobility. However our observations showed that staff practices and records of care provided did not evidence what care had been provided. For example, we saw that for some people who remained in their bedrooms there were drinks available but they were left out of reach of the individual. We saw that for one person a cup of tea had been left on their table and although they did not drink it their fluid charts indicated that they had. Concerns that we received from a relative following our inspection told us that they had seen cups of tea left on their family members table and the records

completed to suggest that the tea had been drunk although they had not. This indicated that the provider could not be confident about the reliability of records We saw that the needs of people living with dementia were not always adequately met by providing a stimulating environment and staff interactions did not help people to make sense of their environment and to be involved in appropriate activities. For example, during our inspection we saw one person in their bedroom removing their bedding. A member of staff went into the bedroom and remade the bedding but did not involve the person in any way.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that applications had been submitted for authorisation from the local authority to ensure that where required people's liberty was only being restricted in their best interest and within legal requirements.

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. Three people's files showed that MCA assessments had been completed. Two people had a mental capacity assessment (MCA) in place which indicated that they could receive their medicines disguised in food if they refused to take their medication .This meant that people were given the option to take their medicines and only if they refused did they receive their medicines disguised in food in line with a best interest decision.

The PIR told us and staff confirmed that they had received training in MCA and DoLS and we saw that they had some understanding of the impact of this legislation on people and knew that DoLS were about people's liberty being restricted so that they could receive care and treatment in their best interest. When we asked a nurse on one of the units about an individual who had had a DoLS application submitted but not yet approved, the nurse told us they were not told about the DoLS until they were approved. This meant that staff may not know why the applications had been made and the implications for the care they were providing. Care plans did not evidence what actions were being taken and that they were the least restrictive options and in people's best interests. For example, one person was on close observations but there was no clear rationale as to why this was required. The individual did have some behaviour that staff could find difficult to manage however this was not recorded as the reason for the close observations. The registered manager told us that they were aware that the records regarding the DoLS were not well organised and they were in the process of ensuring that the documentation was placed on individual files so that staff were aware of the arrangements in place.

People told us that the food was of variable quality. One person told us, "The food is normally good but I don't know what I have ordered today." Another person said, "The food is okay but it's repetitive especially at night." A third person said, "There are two chefs; one is excellent whilst the other one is dreadful, you just can't eat the food." One the day of our inspection we saw that the midday meals were nicely presented and people said they enjoyed the meal. The provider was aware of the issues and plans were in place to address this.

We saw that people's dietary needs were assessed and where unplanned weight loss was identified people were weighed on a weekly basis. People received food that had been prepared in the way that met their dietary and cultural needs. However, during our inspection we were told by managers supporting the home that they had identified an increased number of people who may have had an unplanned weight loss over

the past three months however, they felt this was down to faulty weighing scales and all the weights were to be rechecked. We identified that one person had lost a significant amount of weight over a three month period before a fortified diet was introduced. No referral had been made to the GP for investigation of the weight loss. Although the person's weight had since stabilised this showed that actions had not been taken in a timely manner to address the weight loss. Fluid charts were being completed but there was no monitoring of the fluid intake so that actions could be taken to encourage people to drink more. We raised with the registered provider that our observations had indicated that staff were recording the amount of fluids left in the room rather than what people had actually drunk. A visitor told us their relative took time to take a drink and staff were regularly recording the person had refused drinks rather than spending time to assist them to drink.

We saw that the mealtime experience varied across the different units. On one unit people were brought to the dining room having been told it was lunch time. They were 30 minutes early for lunch and because some people were living with dementia they kept on getting up and walking off as lunch was not there. There were not enough staff available to monitor and assist people who needed support at lunchtime because there were only two staff one of whom was serving meals and the other was taking meals to people in their bedrooms and assisting them with support. When a third member of staff arrived on the unit they did not support staff with the meals but were writing up notes.

We saw that one person who was identified as requiring one to one support was left alone and was seen helping themselves to food off the hot plate. It was only when an inspector alerted a nurse, who was sitting writing up notes did they intervene. Another person was seen walking off with a plate of food in their hand down the corridor and there were no staff around to support them.

On another unit we saw that the dining room was pleasantly laid out with tables able to seat four people. The meals served were well presented and looked appetising. Staff assisted those people requiring help to eat their food in a manner that was polite, offering food in portions manageable to the individuals. On another unit everyone except two people stayed in their bedrooms for their meal.

People told us that they were able to see the doctor if they needed one and the GP visited regularly. One person said, "Yes I can see the doctor when I need to." During our inspection we heard one person complaining about back ache and arrangements were made for the GP to see the person. A visitor told us that they had some concerns following their relative's fall. The staff were uncertain whether the person should have gone to hospital or not but the person was seen by the GP the following day. We had received some concerns that people had not always received medical attention in a timely manner for example, when agency staff were on duty they failed to contact the ambulance when someone said they were in pain and there was a suspected broken bone.

Requires Improvement

Is the service caring?

Our findings

People told us that there were good relationships with the permanent staff. One person told us, "The relationship my family has with the carers is amazing." Another person said, "Our permanent staff know you inside out. There are days when there are only two regular staff and two agency staff on, it is worst at night when two staff are on and one of them is an agency. I cannot see why the regular staff keep getting moved elsewhere."

We saw that care provided was responsive rather than person centred. The staff team were kind and spoke respectfully with people. However, there were limited instances where staff sat chatting with people or encouraging any interests they may have had unless it was whilst carrying out a task such as assisting with meals.

People told us that they were able to make choices such as whether to get up or have a lie in. Choices were available about what food people had to eat and what clothes they wore. However, some people said choices could be improved. For example, one person said, "I would like to go and have lunch in the dining room". A relative also said "It would be nice if he could come out of bed for lunch". The provider has informed us that this issue has been considered and actions taken where appropriate.

There was a sensory room that could be used by people living in the home. We saw that staff used the sensory room for breaks and left items in there including sandwich containers showing a lack of respect for facilities used by people.

We saw that people were treated with dignity and respect. One person told us, "I won't let agency staff handle my naked body, no way." Another person told us, "The staff treat me very, very well, I have a good relationship with them. Do they treat me with respect and dignity, yes they do, and in fact they spoil me rotten." A third person said, "I can't fault the staff they are brilliant, just not enough. They are caring, respectful and respect my privacy and dignity they deserve a gold medal." We saw that there were a number of ground floor bedrooms which looked directly onto the road and public path. The windows in these bedrooms were quite exposed allowing the public, car, buses full view of them lying in their beds. This showed that staff were not always being proactive in ensuring people's dignity and privacy was being maintained although staff were able to tell us ways in which they maintained people's privacy and dignity.

People were not always supported to maintain their independence for example; emergency buzzers were not always accessible so that people could summon assistance when they needed it. We saw that many people were reliant on staff intervention to maintain hydration levels however; one person who could drink independently had their access to drinks compromised due to their inability to reach them. One person told us, "I am fairly independent; I don't require help with my personal care." We saw that people had access to walking frames, wheelchairs and mobility scooters. There was a passenger lift so that people with limited mobility were able to go access different floors in the home. We saw that one person was able to make a hot drink in their bedroom if they wanted and another person collected their clean clothes from the laundry. One staff told us they encouraged people to do as much as they could for themselves.

Requires Improvement

Is the service responsive?

Our findings

Relatives did not always feel that the service was responsive to people's needs. One relative told us, "They [staff] put [person] in bedroom and is basically left there. [Person] has to wait sometimes before someone comes [when they use the buzzer] and is told they are not the only one." They told us that the person had their meals in their bedroom and on at least one occasion they fell asleep and they did not have their meal because no one woke them up to eat it.

We saw that people's needs were assessed before they moved into the home and care plans were in place to meet these needs. One person told us, "I know of a care plan but I can't say I have been involved, but, I have got to give this management a chance." Care plans we looked at were not always completed with sufficient details to show that people's preferences for the way in which they received care was identified. In some cases the records stated that due to people's limited mental capacity they were not able to share their preferences. There was no evidence to show that friends and relatives had been involved in these situations to get information about how they [person receiving the service] liked things to be done.

We saw that people living with dementia did not always receive care in an environment that was interesting and stimulating. We noted that there were not any fixtures, fittings or equipment that encouraged people living with dementia to explore, show an interest in or encourage memories. People were sitting in the lounge and although the television was on no one appeared interested in watching it. There was no other form of stimulation and very little staff interaction with people. For example, during both days of our inspection we saw that one person living with dementia spent time in their bedroom moving things around and removing their bedding from their bed. We saw little interaction with staff apart from when they were putting the bedding back on the bed. This showed that the environment in which people received care was not tailored to their individual needs.

We saw that there were some activities that were being organised but because there was no activities leads currently in the home activities and social stimulation was not well organised. One person told us, "There are no activities, which doesn't bother me but I am sure others miss out." Another person said, "I read an awful lot, there is no point in me sitting in the lounge as there is very little conversation. When activities did take place they didn't suit me. We haven't had anything for a few months." A third person said, "I wish there was more entertainment." A fourth person said, "I have seen my care plan and it even says in there a plan for me going out but it hasn't happened."

We were told that some people did go out but this was limited. During our inspection we saw a member of staff doing some colouring with one person and nail painting with another. We saw that some singers came into the home and some people were taken to the unit that they were performing on.

We saw that many people remained in their beds and there was little engagement from staff other than when carrying out tasks such as replacing drinks. One person was asked what they did all day they said, "Drive myself barmy. I like to watch television but I can't turn over the channels." We noted that the television control was on a chest of draws out of reach of the person.

There were systems in place to gather the views of people that included complaints, comments and compliments, meetings for people and surveys to get people's views about the service. People told us that they were able to raise any concerns they had. One person said, "Any concerns I would go to see the nurse and if no joy go and see the manager." One person told us, "We do have residents meetings but they don't always do what they say." During discussion the registered provider told us that the results of the recent survey showed that people were generally happy with the service provided.

Requires Improvement

Is the service well-led?

Our findings

When asked if people thought the service was well led one person said, "I think so but there are a lot of changes, I think it will be eventually." Another person said, "There is a new manager so it would be unfair to say but she seems clued up, I've got confidence." A third person said, "I do think the home is well run Avery have done such a lot, they have refurbished the first floor and it is beautiful. This floor is going to be done after Christmas." However, some people were not so complimentary. One person said, "Well led, not particularly, no." Another person said, "I think it was until Avery took over."

We saw that the registered provider was making efforts to ensure the service was well managed and had taken steps to ensure that a new registered manager was put in place after the previously registered manager left the service. There was a registered manager in post at the time of our inspection but they had only been in post a few weeks. However, prior to and during our inspection several staff told us they were not happy with the way the home was being managed. Staff told us they did not feel that their concerns were listened to and that staff rotas were only available to them weekly which meant they were not able to plan their personal lives. Some care staff told us that they did feel supported by the nursing and senior care staff. During our inspection one member of staff told us, "This place lacks efficiency and resources, for instance too many large pads and not enough small ones". This issue about insufficient supplies of pads has continued to be raised with us following our inspection by people worried about the care of their relatives. When we initially raised this with the registered manager they said they were aware that the home was running short of these aids but was not sure why this was happening and was taking actions to ensure that this issue was being addressed. The registered provider investigated the concerns and told us that the registered manager was taking control over the ordering and management of incontinence aids from the person who previously ordered them to ensure that sufficient supplies of the correct types were available in the home.

The registered provider was ensuring that we were kept informed about incidents that occurred in the home in line with their legal responsibilities.

Staffing levels and staff turnover continued to be a significant issue in the home and this had resulted in a greater dependence on agency and bank staff. In addition to staff leaving there have been incidents where staff not attending their shifts has meant that staffing levels have been depleted, sometimes for part of shift until cover staff could be located and this has led to some dissatisfaction from relatives and staff. The registered provider was recruiting to cover the staff shortages.

Information that we received from members of the public through complaints and comments showed us that people were not always very happy with the service people received and some relatives were concerned about raising concerns or being identified as having raised concerns. We had received concerns regarding the fact that some people were not being accepted back into the home after an admission into hospital. The registered provider and staff had gone through a difficult period following a serious incident in the home and the registered provider told us that they were looking at the level of need that could be met by the staff in the home and felt that some people had historically been admitted into the home whose needs

were too high.

We saw that complaints were recorded but the complaints log did not show what the outcome of the investigation was or what actions would be taken to prevent reoccurrences. Systems should be in place to monitor the outcome of complaints and concerns to look for themes and trends so that steps can be put in place to minimise a reoccurrence .

CQC have received a number of concerns directly. These concerns indicate that the level of supervision and monitoring of the service in the home is not sufficient and where issues do arise that they are dealt with to the satisfaction of the people raising the concerns. Some relatives told us they had raised concerns regarding a person's care and when they had raised the concerns the acting manager, at the time, had been unsupportive and told them they could call an ambulance as they were unhappy with the care provided. Another relative raising concerns wished to remain anonymous for fear of repercussions. The systems in place should enable people to feel confident to raise concerns directly with the provider and be confident that they will be listened to.

We saw that the registered provider had not ensured that records were accurate and completed as required. We saw that records relating to care did not make accessible to staff any restrictions in place and the rationale for the restrictions in place to ensure that appropriate care was provided. We saw that cream charts kept in people's bedrooms were not sufficiently detailed to show how many times the creams were to be applied. As a result we saw that for one person cream was being applied inconsistently. It had been applied once in the day before our inspection; four times the previous two days but only twice the day before that. We saw that that the issue of administering cream and there frequency had been identified by other professionals who had looked at the management of medicines. One person whose skin patch was to be placed on alternate shoulders did not have a patch chart in place to advise staff which shoulder the patch should be applied on so staff did not put the patch in the same place each day. Fluid charts were not always accurate and monitored to ensure people received adequate drinks.

We saw that the complaints log only went back as far as March 2016 and we were told by the registered provider that they were unable to locate some documents since there had been a change in management. This indicates that the providers systems in place to store information so that it was retrievable were not robust .

The Provider Information Request (PIR) told us that there had not been any medication errors in the previous 12 months. However, an inspection in October 2016 by the CCG had identified multiple medication errors and there were some errors identified during our inspection. This showed that the internal auditing systems in the home were insufficient to identify and address errors that were occurring.

We saw that the provider was undertaking regular checks and quality indicators were measured. For example, the number of pressure sores, weight loss, infections, complaints and incidents in the home were monitored. The information we were provided during our inspection did not show what action plans had been put in place to address any identified issues and how they would be monitored to ensure that the quality of the service was continually improved. We saw that some staff had been brought into the home to assist the home to make improvements. For example, a staff member who had knowledge of what good care for people living with dementia was like and another member of staff looking at weight loss and management of unplanned weight loss. We saw that systems such as the 'resident of the day' where an identified person and their care needs would be focussed was not being used to best effect. The registered provider was already aware of this. However, overall the management and monitoring of the service had not been sufficient to ensure that people receive a safe, good quality service and shortfalls in the service are

identified, addressed in a timely manner and improvements sustained.

This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against the risks of not receiving their medicines as prescribed. Regulation 12 (1) (2) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not robust enough to ensure that the service was assessed, monitored and improved to assure the quality and safety of the services provided to people; to ensure that an accurate and complete record was maintained for each person receiving a service including including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided and ensure that all records were stored safely and easy to retrieve. Regulation 17 (1)(2) (a)(b)(c) and (d)