Ainsworth Nursing Home Limited

Ainsworth Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Ainsworth Nursing Home was inspected on the 12 May 2015. The overall rating for this provider was 'Inadequate'. This meant that it was placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use of enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The service was inspected again on 5 and 6 January 2016 when we undertook a further comprehensive inspection to see if improvements had been made since the service was placed in 'special measures'. Multiple breaches of the regulations were found again and the condition to restrict further admissions to Ainsworth Nursing Home on the 14 September 2015, remained in situ. The service was rated as "requires improvement" with one domain rated "inadequate" and therefore remained in 'special measures'.

This was an unannounced comprehensive inspection which took place on 6, 7 and 8 June 2016. We have rated the service as "inadequate" and therefore the provider remains in 'special measures'. This inspection found that there was not enough improvement to take the provider out of 'special measures'. CQC is now considering the appropriate regulatory response.

Ainsworth Nursing Home is situated in the village of Ainsworth, in a rural position. Ainsworth Nursing Home provides nursing and residential care for up to 37 older people including people with mental health and dementia needs. There were 23 people living there on the day of our inspection.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the

Health and Social Care Act 2008 and associated Regulations about how the service is run. The service has been without a registered manager since 1 February 2016 when we cancelled the previous registered manager due to their unfitness. The provider had promoted the deputy manager but they withdrew their application to register as the manager. A new manager had been appointed, however they had only been in post three weeks.

During this inspection we found continued and new breaches of the regulations. You can see what action we told the provider to take at the back of this report.

Staff members did not understand their responsibilities in relation to safeguarding people who used the service. During our inspection we found issues relating to the safe care and treatment of people that required a safeguarding alert to be raised with the local authority.

Staffing levels were not consistent with what we had been told by the manager. We found occasions when there were not the amount of qualified nurses or care staff on duty that the manager told us there should be. We also witnessed an occasion during our inspection where the dementia unit had been left without any staff members for approximately five minutes; resulting in people being left unsupervised. This left vulnerable people at risk.

We looked at all the records relating to fire safety. We saw these checks had not been completed since the 17 May 2016, when the maintenance person went on leave. This meant any fault would not be discovered until the maintenance person returned to work. We found the only fire drill that had been completed within the service was done on the 13 August 2015 by a fire consultant who had attended the service to provide training to the staff members. Robust systems need to be in place to ensure the premises are safe and staff know what to do in the event of an emergency so that people kept safe.

People were still not protected by robust recruitment practices ensuring only those suitable to work with vulnerable people were employed to work at the service.

A nurse who worked in the service had conditions placed on their registration. One condition was that they did not work unsupervised when on duty. However records we looked at showed that the nurse had worked unsupervised as the only qualified member of staff on duty on a number of occasions.

Medicine administration records (MAR's) we looked at showed some people were to be given 'when required' (PRN) medicines. We found evidence to suggest that people were being given this type of medicine at times when it was not required or in accordance with the prescriber's instructions. Following our inspection we raised a safeguarding alert with the local authority.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. The cook asked people what they wanted for their lunch the day before; it is unlikely that those people living with dementia would remember what choice they were given. We did not see any evidence that people who used the service were involved in the development of menus; the cook decided what people would be offered for lunch and evening meal. Nutritional care plans were not always followed.

We found there was a continued lack of missed opportunities to engage and stimulate people to relieve boredom.

During our inspection it was necessary to speak to the manager and provider regarding the attitude of one

staff member. We observed them to be disrespectful and patronising in their interactions with people who used the service and the expert by experience.

The provider had not notified us of changes to the service statement of purpose as required in the regulations and continued to show a lack of understanding of their responsibilities in relation to the regulations.

We looked at the personal care records for four people who used the service. We found that one person's records showed they had not had a shower for 25 days, another person told us they wished to have a shower daily although records showed they had only received 12 showers in a three month period and another person's records showed they had received one shower in the same three month period. This demonstrated that care records were not up to date, accurate and did not reflect the care and treatment being provided.

We looked at four re-positioning charts that were in place for those people who were at risk of developing pressure ulcers. We noted that all the charts were pre-printed with the times 08:00am, 10:00am, 12:00noon, 14:00pm and so on every two hours. We found records did not accurately reflect the time when support was offered, there were omissions in records and information was unclear about where the person had been repositioned, for example their armchair or bed thus placing them at risk of developing pressure ulcers. We noted there was no one in the service with a pressure ulcer at the time of our inspection.

The policies and procedures we looked at on the day of our inspection were not relevant to the service. Until new policies and procedures were developed that were relevant and staff had read and understood them, there was limited guidance for staff to follow.

We saw a lack of robust quality assurance systems in place within the service. The provider had failed to understand the importance of monitoring and assessing the service provided so that people were kept safe. This resulted in us making three further safeguarding alerts following this inspection.

The manager was in the process of arranging specific training for staff members such as catheter care, epilepsy, Parkinson's disease and the use of thickeners.

All the relatives we spoke with spoke highly of Ainsworth Nursing Home and felt their loved ones were safe, well cared for and that staff were kind and caring.

We noted bedrooms and communal areas were clean and tidy with no malodours. We saw in each bedroom there was a cleaning schedule. This covered dusting, hovering, emptying bins, and cleaning windows.

We observed staff wearing appropriate personal protective equipment (PPE) such as aprons and gloves. We saw that PPE was changed according to the task they were carrying out, such as personal care or serving food.

We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body (local authority). The provider had notified CQC as required by legislation where authorisations had been made.

We found the kitchen was clean and well organised with sufficient fresh, frozen, tinned and dried food stocks available.

Relatives were given the opportunity to comment on the service through satisfaction surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not understand their roles and responsibilities in relation to safeguarding and policies and procedures in place were not specific to the service in order to guide staff.

The provider had not taken all reasonable steps to help manage and reduce the risks ensuring the health, safety and welfare of people who used the service. Risk assessments did not contain sufficient information to guide staff and keep people safe.

Regular health and safety checks were not carried out in the absence of the nominated person and equipment, such as foot stools, was not always available for people who used the service.

We saw staff had access to personal protective equipment (PPE) such as aprons and gloves. We saw that PPE was changed according to the task they were carrying out.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular supervisions and appraisals and qualified nurses had not received clinical supervision.

People were not consulted in menu planning, were not given sufficient time to eat and nutrition care plans were not always followed.

The manager was implementing training for staff in the specific needs of people, for example, catheter care.

We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body (local authority). The provider had notified CQC.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw some of the language used by staff when writing care plans and recording notes in care files was negative and not respectful of people. Our observations of some staff did not demonstrate they had a good understanding of how to interact with people living with dementia in a dignified way.

End of life care plans we looked at were old ones and needed to be re-written in the new format that was being developed by the manager.

Feedback we received from relatives was positive. They told us staff were kind and caring in their interactions with their loved ones.

We found all care records were stored in locked cabinets and only staff members had access to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a continued lack of opportunities for people to stimulate them and prevent boredom.

Care plans in place were not accurate to ensure safe and effective care was provided in a consistent way.

Care records we looked at showed that people's needs had been assessed prior to moving into Ainsworth Nursing Home. This helped the service decide if the placement was suitable and if people's needs could be met by staff.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service.

The provider has continually failed to demonstrate that they have a good understanding of the Regulations and their responsibilities within these.

The service had no effective systems in place to continually monitor the service provided to ensure people received safe and effective care.

Relatives of people who used the service told us they had

opportunities to comment on the service through satisfaction surveys.

Ainsworth Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6, 7 and 8 June 2016 and was unannounced. The inspection team consisted of two adult social care inspectors 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 service.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. We did not request a Provider Information Return (PIR) because the provider would not have had sufficient time to complete it. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain their views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We received a response from the local commissioning team who informed us they had no current concerns with the service.

Since our last inspection we received a number of letters and emails from the relatives of people who used the service who wished to tell us of the positive aspects of care their loved ones experienced . Relatives wrote to us to tell us about their perspective of Ainsworth Nursing Home. We considered their comments when planning the inspection and they have been included throughout this report.

During our time on site at the home we spoke with four people who used the service and five relatives. We also spoke with two qualified nurses, three care staff members, the cook, the maintenance person, the manager and the provider.

We looked at the care records for eight people who used the service and the medication records for a

number of people. We also looked at a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

We asked people who used the service if they felt safe and free from bullying. One person told us, "Sometimes" but when asked further questions they were referring to not feeling safe with their own mobility. Another person stated, "In a way I do, but in a way I don't" but could not tell us why they felt this way. Another person told us, "I just feel comfortable." We asked people living at the home if they knew what to do if they did not feel safe. They told us, "No", "I'd talk to one of the carers" and another person told us they would speak to the manager, although named the previous registered manager who no longer works at the home.

We also spoke to people's relatives to ask if they thought the care their loved ones were receiving was safe. Comments we received included, "It's a secure building and she's well looked after", "I have come at various times and my daughter has, and we have not found any injury or been upset", "I come every day and make sure" and "There's security on all the doors and the staff are watching all the time."

Prior to our inspection we received a number of letters and emails from relatives of people who live at Ainsworth Nursing Home. One person commented, "Whenever I have asked my wife does she feel safe she has always said she feels safe. Whenever I have asked her if she is treated well and the staff has not misbehaved with her when I am not there she has always replied that she has no complaints against any of the staff."

We asked staff to tell us how they kept people safe. They told us, "We watch them and by walking with them" and "Checking the risk assessment, care plans and looking at daily needs." We also asked staff members if they had received training in safeguarding and what it was. One person stated, "Moving and handling, had it a few months ago." Another staff member told us, "I had it last year, it is like whistleblowing." When asked how they would protect vulnerable people from other service users who may be aggressive, one staff member said, "We don't have that here." Another staff member told us, "We don't leave them alone, it does happen." We also asked staff members what incidents they felt might need to be reported. One staff member stated, "Falls and if they go downhill." Another staff member stated, "Any slip, trip or fall." None of the staff members we spoke with had a good understanding of safeguarding and/or their responsibilities despite records showing most staff had undertaken training.

One visiting professional when asked about safety said "I don't think there are any concerns, I'm not aware of any incidents."

We asked the manager to show us the safeguarding policy in place within the service. We were given a policy that made reference to another care service and were told this was a working document. We also saw evidence to show that staff had read the policy and signed to say that they understood it. We discussed this with the manager and on the second day of our inspection were given a new policy and procedure they had just developed. This policy covered the different types of abuse and reporting procedure. When in place and read by all staff this should provide staff members with adequate information and direction.

This meant there was a breach of regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not understand their roles and responsibilities and policies and procedures in place were not specific to the service in order to guide staff.

At our previous two inspections we found information contained within risk assessments did not accurately reflect the current needs of people. They also did not contain sufficient information to help guide staff so that appropriate action was taken to minimise risks to people. During this inspection we found insufficient improvements had been made. This meant that people who used the service continued to be placed at risk.

We looked at eight care records in relation to risk assessments. We found one person had a moving and handling risk assessment in place. However, we noted that this person had been sat in a sling all day on all three days of our inspection. There was no mention in the risk assessment about why there was a need for a sling to be used, the type of sling to be used or how staff members were to use the sling. There was also no mention if it was safe for the person to be sat in the sling all day. We spoke with two members of staff during our inspection to ask why the person was sat in the sling. We were told, "[Name of service user] is very difficult to move to get the sling in place every two hours. She slips down during hoisting" and "The care staff say it is difficult to keep putting on." We asked both staff members if this was to assist the staff and make it easier for them and both replied "Yes." This meant that leaving the sling in place was to aid staff and not what was best for the person who was at high risk of sore skin.

Care records we looked at also showed that another person could often display behaviours that challenged. We saw there was no risk assessment in place in relation to the types of behaviour they may present with, how staff were to manage these behaviour or what type of techniques to use. This meant staff may not deal with the situation correctly and place the person and themselves at risk.

We saw four risk assessments were in place in relation to the environment. These were ironing/toaster/kettle/microwave/geezer, computer screen equipment, mopping kitchen floor and using hoists and slings (this looked at identifying faulty hoists and slings and did not guide the staff in using them correctly). We found these were basic and did not include in-depth information and some were not fully completed. There were no risk assessments in place in relation to any other environmental hazards such as fall from heights, lone working, pregnant workers and kitchen safety.

The provider had not taken all reasonable steps to help manage and reduce the risks ensuring the health, safety and welfare of people. This was a continued breach of Regulation 12 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service if they felt there was enough staff on duty to meet their needs. Comments we received included, "Sometimes" and "Sometimes, I'm not sure. Sometimes it's hard to find staff." Another person felt there was enough staff on duty. We also asked people how long they had to wait for assistance. People told us, "I get fed up of waiting for a shower", "We have to wait 20 -30 minutes, but sometimes they're on time" and "Not so long".

One relative who wrote to us prior to our inspection told us, "We have noticed an improvement in the level of supervision of residents; there is now one of the carers on hand to provide for the residents and to give companionship."

Staff members we spoke with told us most of the people on the dementia unit required two people to assist them. One staff member told us, "Sometimes we need three staff to support people, they can get a bit violent if trying to shower or change them. One staff talks to them whilst two take their pants off (referring to

when undertaking personal care)." We asked care staff members what they thought about the staffing levels within the service. Comments we received included, "We could do with more, not everyone is reliable", "Staffing levels are a lot better than they used to be. If there is only two staff and three need assistance we do our best. We need three care staff in there (dementia unit), we are juggling everything. We don't drink enough because we don't have time" and "It is getting a bit better; we could do with more after 4pm. The residents start wandering and banging into each other. We need another person in the lounge."

The manager told us staffing levels within the service consisted of two qualified nurses and four care staff members from 8am until 2pm, one qualified nurse and four care staff members from 2pm until 9pm and one qualified nurse and three care staff members from 9pm until 8am. The manager told us "Staffing levels are fine at the moment but if any more people move in we would need more staff."

We looked at the rotas covering the period 16 May 2016 to 12 June 2016. We found that on eight separate occasions there was only one qualified nurse on duty from 8am until 2pm instead of two. On the 24 May 2016 there was one care staff on duty on the dementia unit for the day. On 18 May 2016 there was one care staff on duty on the dementia unit from 8am until 3pm. On the 23, 25 and 31 May 2016 there was one care staff on duty from 3pm until 9pm. On 3 June 2016 there was one care staff on duty on the general unit from 6pm until 9pm. We also looked at the night staff rotas. We found that on four separate occasions there was one qualified nurse on duty with two care staff instead of three. Therefore at times throughout the day there were only two members of staff on the dementia unit providing care and support to people who in the main required two people to assist them. This meant there was potential for people to be left unsupervised and at risk.

These matters are a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at all the records relating to fire safety. We saw the maintenance person was responsible for the weekly checks of the fire alarm system, fire extinguishers and emergency lighting to ensure they were in good working order. However, we saw these checks had not been completed since the 17 May 2016. Nobody within the service had been nominated to undertake these safety checks in the absence of the maintenance person. This meant any fault would not be discovered until the maintenance person returned to work.

We saw the service had a detailed fire risk assessment in place dated 31 July 2015. People who used the service had a Personal Emergency Evacuation Plan (PEEP) in place to be used during an evacuation. However, we found the only fire drill that had been completed within the service was done on the 13 August 2015 by a fire consultant who had attended the service to provide training to the staff members.

The lack of weekly checks on equipment and the lack of regular fire drills for staff meant people were at risk in a fire situation. These matters are a breach of regulation 12 (1) and (2)(a)(d) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection we checked records to ensure that portable electrical equipment had been tested (PAT) to ensure its safety. We were informed that the maintenance person was responsible for all PAT within the service. From our discussions with the maintenance person and the provider and a review of records, we saw no evidence that this person had undertaken any training or was deemed competent to undertake these tests safely. During this inspection we noted the maintenance person had completed the relevant training and was deemed competent.

At our previous two inspections we did not see any evidence that wheelchairs and walking aids were

checked on a regular basis to ensure they were safe and appropriate for use. During this inspection we found these checks had been completed weekly until the 19 May 2016 when they stopped. The maintenance person was responsible for these checks and had gone on annual leave around this date and nobody had been identified to continue these checks in their absence. This meant that any faults would not have been identified until their return to work. We discussed this with the manager about the importance of required checks continuing to be undertaken when the person responsible is on annual leave.

Two records we looked at showed one person on the general unit and one person on the dementia unit had swollen legs due to oedema. We asked staff on the general nursing unit how they would elevate someone's legs if they were swollen and this was a method of treatment. We were shown three chairs that reclined with a leg rest. There were no other reclining chairs available should there be more than three people who needed their feet to be raised. We asked the same question of the staff on the dementia unit. There were no reclining chairs on this unit. The staff member told us, "[service user name] has swollen legs and we try to encourage him to go to his room and sit in his reclining chair but he is often uncooperative. Sometimes he will just walk down to his room on his own." On all three days of our inspection we noted this person had no opportunity to raise their swollen legs.

These matters are a breach of regulation 15 (1)(e) and (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as regular health and safety checks were not carried out in the absence of the nominated person and equipment was not always available in communal areas for people who used the service.

At our previous inspection we found robust recruitment practices were not in place ensuring only those suitable to work with vulnerable people were employed to work at the service. We identified the policy and procedure still needed updating to reflect all checks required. This is important so that all necessary information and checks are completed to demonstrate applicants are suitable for employment. During this inspection we were given a policy that made reference to another care service and were told this was a working document and saw evidence to show that staff had read and understood this. We discussed this with the manager and on the second day of our inspection we were given a new policy and procedure they had just developed. Once this is in place and a working document it should ensure recruitment practices are robust.

Other shortfalls found at the last inspection included the names of applicants and dates were not recorded on references prior to being sent to referees, application forms for two people were incomplete and did not include a full employment history or provide details of the referees, on two files there was no evidence of a Disclosure and Barring Service (DBS) check and interview records had not been completed for each applicant or lacked information about the discussion held. These records help to demonstrate that those people appointed to work at the home have been assessed as having the qualities and skills needed and are deemed as suitable to work with vulnerable people.

At this inspection we examined the files for 4 staff who had been employed since our last inspection. We found information included an application form, written references, copies of identification, interview notes and a Disclosure and Barring Service (DBS) check. However we found that the system in place was still not robust. For example on one file the reference request letter was undated; a character reference received was not addressed to staff at the home, there was no date and the name of the person providing the reference was unclear; this had not been verified to check the information. On a second file, gaps in employment had not been explored. We also found interview records were vague, incomplete and did not explore the knowledge and skills of applicants so that an informed decision could be made about their suitability for work. On one file there was no record to evidence an interview had taken place. The manager told us this

interview had been completed by her following her recent appointment; however the notes had not been filed.

People were still not protected by robust recruitment practices ensuring only those suitable to work with vulnerable people were employed to work at the service. This was a breach of Regulation 19 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the manager and administrator that a new system was to be implemented to monitor registered nurses working at the home confirming they had a current registration with the Nursing and Midwifery Council (NMC); ensuring they remain authorised to work as a registered nurse. These checks would be completed on appointment and reviewed on a monthly basis. We were told the provider would also carry out monthly checks to ensure information was accurate and up to date, however this had not yet been implemented.

On one file we looked at we noted a letter from the Royal College of Nursing (RCN) in relation to a nurse where conditions had been placed on their registration. These conditions had been made by the Nursing and Midwifery Council (NMC) due to issues identified in their clinical practice with regards to the safe administration and management of people's medicines. We asked the provider what action had been taken to address the recommendations outlined in the letter.

We were told by the provider they had contacted the RCN to discuss the matter and we saw evidence of this had been recorded. The provider also told us that as specified under the conditions, the nurse worked alongside another nurse when on duty. However on examination of staff rota's we found occasions when the nurse was the only qualified member of staff on duty and therefore was not being supervised. For example on the 2 May 2016 the nurse worked unsupervised between 1pm and 8pm; on the 9 May 2016 the nurse worked unsupervised between 2pm and 9pm, on the 16 May 2016 the nurse worked alone all day, 8am to 9pm and on the 3 June 2016 the nurse worked unsupervised between the hours of 8am and 10am. This also meant the nurse was giving out medication unsupervised as they were the only qualified on duty.

This meant there was a breach in Regulation 12 (1) and (2)(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people we spoke with told us they received their medicines on time.

During our last inspection we found that improvements had been made with regards to the management and administration of people's medicines. During this inspection we again checked the systems for the receipt, storage, administration and disposal of medicines.

We found medicines were stored securely in a locked trolley and were only accessible to nursing staff. We saw the trolley on the nursing dementia care unit was kept in the treatment room, however on the general nursing unit the trolley was kept in the staff office. We saw this room was kept locked when unoccupied. The manager told us that an empty room, previously used as the smoking room was being refurbished to provide a 'treatment room' for the general nursing unit.

We looked at the medicine administration records (MARs). These were completed in full. Records were signed to show they had been checked on receipt, a record was made where stocks had been carried forward and written entries and been signed be two members of staff. This helps to ensure the information recorded is accurate.

We found that appropriate arrangements were in place for the ordering and disposal of medicines and the controlled drugs prescribed for people (very strong medicines that may be misused) were stored safely in accordance with legal requirements and stocks corresponded with the register in place.

The MARs we looked at showed that some medicines were to be given 'when required' (PRN). We saw that information was available to guide staff when this medication may be required. However on examination of two people's medication administration records (MAR) for the month prior to our inspection we found that a PRN medication, prescribed for agitation had been administered at night time on almost a daily basis. The MARs stated that this was due to 'restlessness'. However when we examined the daily reports for these people there was no information to show that they had been unsettled. There was also no evidence to show that should a regular dose of medication have been required that this had been discussed with the person's GP. This meant nursing staff were administering medication to people at times when it was not required or in accordance with the prescribers instructions. Therefore this did not demonstrate people were protected from improper treatment. Following our inspection we contacted the local authority regarding our concerns around people being unnecessarily sedated.

This meant there was a breach in Regulation 13 (1) and (4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we identified concerns about the use of prescribed 'thickeners'. Thickeners' are added to drinks, and sometimes food, for people who have difficulty swallowing. We found that care staff responsible for supporting people with their nutritional intake, were not provided with clear guidance about how thickeners were to be used. We also identified that nurses had signed on the MAR that they had given prescribed thickeners, despite this being done by care staff and therefore did not provide an accurate account of administered a prescribed item.

During this inspection we found information in people's care records had been expanded upon to show what the person required. Monitoring sheets were in place and had been completed by care staff each time a drink, including thickener, had been provided.

On examination of one person's file we saw that they had previously been assessed by the speech and language therapist (SALT) in 2013 at which time they were prescribed two scoops of thickener per 100mls of fluid. There was no evidence of further assessment having taken place. To ensure that the prescribed dose continues to be the right dose a further assessment is needed. We looked at this person's fluid intake charts. Information showed that this guidance was not always followed. Records we looked at for the month prior to the inspection showed that on six days the amount of thickener provided did not correspond with the guidance, with staff documenting two scoops per 200mls of fluid instead of the four scoops required in 200ml. This meant the person may not have been receiving the correct amount of prescribed thickener placing them at risk of choking. We discussed our concern with the provider and manager. The manager advised us that due to the changing needs of this person a reassessment would be requested.

We looked at how staff supported people where they had been prescribed topical creams. We were told by the nurse that these creams were applied by care staff when assisting people to rise or retire or following personal care. Care staff were to record on a separate MAR chart when this had been applied. We were told that the MAR charts and a body map were kept in the person's own room and were therefore easily accessible to staff when assisting people.

We looked at the MAR records for three people. We found that one person did not have a body map. Information detailed on the two maps seen did not clearly identifying the prescribed cream and where this

was to be applied. The MAR sheet did not always clearly direct staff when creams were required. For example, on one sheet information stated the cream was to be applied 'as directed'. When we asked the nurse what this meant we were told that this item was PRN. However the nurse was unable to provide us with information to show this had been confirmed with the person's GP. On this person's MAR and body map the name of the cream differed. This item was to be applied twice daily however the new record commencing the 6 June 2016 was incomplete.

On a second person's records the items prescribed on the MARs did not correspond with the body map, there was no start date recorded on the form therefore it was unclear if this was still required. When we checked the care records for two of these people, we found that information made reference to topical creams being required to treat a medical condition however there was no further guidance for staff in relation to the application of topical creams.

We were told by the manager that all the qualified nurses had to complete a competency assessment to ensure they had sufficient knowledge and skills to administer medicines. The records we looked at showed that three qualified nurses had commenced a competency assessment but none of them had completed it. We were therefore unsure if these people were deemed competent to administer medicines safely and the provider had no assurance of people's competency.

We saw the last weekly audit for medicines was carried out on 22 April 2016, meaning no regular checks were being carried out to ensure medicines were being stored and administered safely.

It is essential that relevant information is available for care staff and recorded accurately to ensure that people are given their prescribed medicines safely, consistently and as prescribed. This meant there was a breach in Regulation 12 (2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us the service was clean. We asked relatives if they felt the service was clean. Comments we received included, "Parts that I've seen are", "It's very clean" and "It's a lot better than it was. They try to keep on top of things."

We spoke with staff about their responsibilities in relation to infection control. One staff member told us, "Make sure there is no cross contamination, wear aprons and gloves." Another staff member told us "Washing hands and using gel."

Records we looked at showed the service had an infection control file in place. This contained information such as hand washing, cross infection and good practice guidance from the Department of Health on preventing the spread of infection. We also saw risk assessments were in place in relation to cross infection. There was a nominated staff member who had responsibility for all issues relating to infection control and a quarterly audit was undertaken.

During our inspection we noted bedrooms and communal areas were clean and tidy with no malodours. We saw in each bedroom there was a cleaning schedule. This covered dusting, hovering, emptying bins, and cleaning windows.

We saw staff wearing appropriate personal protective equipment (PPE) such as aprons and gloves. We saw that PPE was changed according to the task they were carrying out, such as personal care or serving food.

Requires Improvement

Is the service effective?

Our findings

We spoke with care staff to ask if they received regular supervision and appraisals. Comments we received included, "Carers don't have any backup, no supervision" and "We have supervision monthly and appraisals yearly. We never get any praise apart from relatives."

Records within the service stated that staff members were to have a minimum of six supervisions a year. We looked at the supervision and appraisal records for all the staff working at Ainsworth Nursing Home. We found that two staff members had received supervision since our last inspection, two people had not received supervision since January 2011 and the remaining staff had not received supervision since 2015. Records we looked at also showed that only one staff member had received an appraisal and this was on the 30 December 2014.

During our last inspection we did not see evidence of clinical supervisions being undertaken with nursing staff to discuss their clinical practice, current good practice guidance and any development needs. Supervision records for qualified nurses showed that none of them had received clinical supervision since our last inspection. Supervisions and appraisals are important as they help staff discuss their progress at work as well as discuss any learning and development needs they may have.

Opportunities for staff training and development helps to ensure the specific health and well-being of people are safely met by staff with the relevant knowledge and skills needed to do so. This meant there was a continued breach of Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We looked at the kitchen and food storage areas and spoke with kitchen staff.

We observed the lunch on the dementia unit on the first day of our inspection. We noted that apart from one person who did not eat their entire main course, nobody was given a choice of what they wanted. Staff told us that the cook asked people the day before what they would like for their lunch (a choice of two main courses). Given that everyone on the unit was living with dementia it is unlikely that any of the people who used the service would remember what choice they were given the day before. No additional tools had been devised to assist with helping people to make choices, such as two meals being cooked and people being offered a choice visually or verbally of what was on offer.

Two people were being assisted to eat their meal by staff members. We noted that both staff members were very quickly putting spoonful's of food into people's mouths without giving them the opportunity to finish what they were eating. We did not see either staff member offer these people a drink throughout their meal. Upon checking one of the person's care plan it was noted that staff were to be patient and encourage food intake as they can be reluctant to eat. We did not see this in our observations.

We spoke with the cook on the second day of our inspection. They told us that they decided, without consultation with people who used the service and relatives, what choices went onto the menu, which was a four week rolling menu. This did not include breakfast as people who used the service decided what they would like at the time and could have a choice of items such as cereals, toast or cooked breakfast. We did not see any evidence that any observations of what people looked to enjoy were undertaken. There were also no systems in place where they were able to identify high food wastage which would show the meal was not enjoyed. This meant that there was no consideration made to what people who used the service liked or wanted.

We were told by staff members and the cook that people who used the service could have hot and cold drinks when they wanted. We saw that staff members came round with a drinks trolley at various times during the day and offered tea, coffee, orange juice and blackcurrant. We asked if people could have water and were told "The residents don't like water." Therefore this choice was not given. This does not evidence best practice guidance in relation to promoting and ensuring good hydration levels.

During our lunchtime observations we saw that one person had three glasses of cordial. A care staff member asked the person if they wanted more but before this could be given another staff stated "That's his third glass." The care staff member then told the person they could have more later. We checked the person's care plan for eating and drinking. This stated they needed prompting to take adequate food and fluids. This meant the opportunity for the person to make their own choice to drink without prompting was taken away from them and care plans were not followed.

We overheard a staff member state that one person who used the service had not been eating much. A review of the food and fluid chart showed entries for each meal time, however did not state how much had been eaten/refused. This meant it would not be possible to gain an accurate reflection of what the person was consuming and if this was adequate for their health and well-being.

Monitoring charts were kept in people's own rooms. Therefore records for those people who spent their time in communal areas were not easily accessible. We observed two staff members completing food and fluid charts for breakfast at lunchtime, consulting with each other about what people had eaten. As these had not been completed at the time, and having to consult with each other there is potential for these to be an inaccurate reflection of what the person had consumed.

These matters were a breach of regulation 14 (4)(a)(c) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not consulted in menu planning, people were not given sufficient time to eat and nutrition care plans were not always followed.

We asked people who used the service about the meals. Comments we received included, "I enjoy it. I get enough, but can ask for more. You can have what you want", "I like some and some I don't. You can have a choice" and "It's alright. I could probably have something else."

Prior to our inspection we received a number of letters from relatives of people who used the service. One relative told us, "He is well cared for, weight stable and being type 1 diabetic, insulin and medication is monitored daily and nutrition is catered for."

We found the kitchen was clean and well organised with sufficient fresh, frozen, tinned and dried food stocks available. We saw records were completed in relation to temperature checks, cleaning schedules and meals served each day. The cook was aware of people's dietary needs and how to fortify foods to improve a person's nutrition.

Following a food hygiene inspection on November 2015, the home was rated a '4'. A rating of five being the highest awarded.

We asked people who used the service if they felt staff had the knowledge and skills to meet their needs. One person told us they felt they did. Relatives we spoke with told us, "The ones that look after [relatives name] have been here a long time", "Certainly recently, it's been very different", "I think they are skilled, sympathetic and caring", "Yes", and "They're overworked and underpaid".

We asked staff members how well they knew the people they were caring for. Comments we received included, "Pretty well. I've not read the care plans yet" (despite the staff member working at the service for two years) and "I read the care plans and the social history." One relative who wrote to us prior to the inspection told us, "There have been very few changes of staff whilst he has been a resident and this provide continuity and stability for my [relative], something which is important to him and which my wife and I value tremendously."

During our last inspection we identified that further opportunities for staff training and development were needed for both nursing and care staff. This helps to ensure staff have the right knowledge and skills needed to safely meet the specific health care needs of people.

At this inspection we looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Ainsworth Nursing Home. We spoke with the manager, staff and examined training records to see what training opportunities had been made available.

Staff members were asked about their induction. One person told us, "I have done this job for years" and another person could not remember if they had done an induction.

In relation to the induction process for new staff we saw that an 'introduction' sheet was completed on each of the unit. This involved the new staff being shown around the home, relevant policies and procedures were explained and they were introduced to people living at the home and their care records. New staff also spent time working alongside experienced members of the team. On one day of our inspection we saw a new member of staff being inducted by the nurse on duty. The manager also told us that they were to introduce DVD training as part of the induction, providing an overview of the care and supported expected from staff.

We asked staff members what training they had completed over the last 12 months. We were told, "Thick and easy, infection control, fire and moving and handling" and "moving and handling, thick and easy, epilepsy and fire training." Both staff members we spoke with told us they had a National Vocational Qualification (NVQ) two and one also had level three. One staff member also had a Diploma in dementia.

The manager told us that training was accessed through the local authority training partnership scheme as well as external providers and e-learning. We were told that over the last year training had been provided to the care team. Records seen showed that recent training had included; moving and handling, health and safety, fire training, safeguarding, Mental Capacity Act and DoLS. We were also told that nursing staff had completed a four day pressure care training programme with the clinical commissioning group. Evidence of this was seen on one of the staff files we looked at. Additional training had been planned for the team for June 2016. These courses included Parkinson's, epilepsy, fire safety and training in the use of thickeners. The manager told us there was an expectation all staff attended all training. We saw staff attending training on fire safety and the use of thick and easy during the inspection.

The manager also told us that further training was being sourced in specific areas of care. These included

training in catheter care as well as end of life care and training from the speech and language therapist in relation to nutrition and swallowing. At the time of the inspection dates, times and attendees had not been arranged.

We also asked the cook what training they had undertaken in relation to their role. They told us they undertook all the training that care staff members did and they had completed a Level 2 award in food safety in catering. However, we noted that this was completed on the 2 February 2010 with a refresher being recommended in February 2013. The cook told us they had not completed any further refresher training. The staff training matrix confirmed what we had been told. The manager told us they would look into this and arrange for refresher training.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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 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. We asked to see the MCA/DoLS policy in place. We were given a policy that made reference to another care service and were told this was a working document and saw evidence to show that staff had read and understood this. We discussed this with the manager and on the second day of our inspection we were given a new policy and procedure they had just developed.

We asked people who used the service if they felt restricted in anyway. People who used the service told us "I can't go out, but I don't know why" and "I have been out this morning."

We saw information to show that authorisations to deprive people of their liberty had been made to the relevant supervisory body (local authority). The provider had notified CQC as required by legislation where authorisations had been made.

We asked one staff member if they had received training in MCA and DoLS. They told us, "Yes, it doesn't mean they are not free to go. They need extra care and they've gone worse. I can't think at the moment."

We looked at how people were consulted and consented to their care and support. We were told and saw examples in two files of where people had been involved. We saw that one person had expressed a wish not to sign their records; however staff had recorded their views. The other person had signed the front of their plan, a copy of a review form and a consent form in relation to sharing information.

We asked how decisions were made for those people who were not able to make decisions for themselves. We were told that staff would liaise with families so that relevant information could be gathered. One relative we spoke with said that whilst they had not read their relatives care records they had been consulted with and were aware of what support had been put in place.

We did note however on one file a consent form had been signed by staff in May 2016 stating verbal consent

had been given by the person for their bedroom door to left open. This contradicted the information on a best interest form completed by staff in October 2015, which stated the person was 'unlikely to regain capacity' although there was no evidence that a mental capacity assessment had been completed. On the records for a second person we saw staff had recorded 'refused to consent' when the person had been asked if staff could withhold their cigarette lighter. We discussed this with the nurse who said that this was inaccurate and the person had given their consent however had refused to sign the records.

Whilst training records showed that training in MCA and DoLS had been provided to nursing and care staff during the last 12 months. Those staff we spoke with were not clearly able to demonstrate their understanding of the MCA and DoLS procedures. This training is important and should help staff understand that assessments should be undertaken, where necessary, to determine if people have capacity to make informed decisions about their care and support. It should also help staff understand that where a person lacks the mental capacity and is deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe. The provider has a duty to ensure that staff understand their responsibilities so that relevant law and guidance is adhered to.

The manager told us that consideration was being given to the layout of the building, which may result in people moving rooms. We were told that these decisions would not be made in isolation and where appropriate families would be consulted with as well as commissioners so that a decision could be made in the person's 'best interest'. These meetings are important so that the rights of people who lack the mental capacity are protected.

One relative who wrote to us prior to our inspection told us, "When [name of service user] has any health issues, his medical needs are attended to without delay and he is visited by a nurse or GP when appropriate."

Records we looked at showed people had access to a range of healthcare professionals in order for their health care needs to be met. Records we looked at showed that visiting professionals included GP's, dietician and tissue viability nurses.

We found signage placed around the home to assist people living with dementia. This included pictorial signs to identify toilet and bathroom facilities as well as photograph's on bedroom doors. The use of pictures and other visual aids helps to promote the independence and orientation of people living with dementia.

A relative who wrote to us prior to our inspection told us, "[Relative] has a pleasant, spacious room which is kept very clean and always tidy. His clothes are neat and laundered regularly and his belongings are treated with respect." Another relative wrote, "Since the inspection and departure of the former manager and the appointment of the deputy manager (who is no longer in post as the manager), we have notice many improvements to the provision at Ainsworth, not only to the fabric of the building but, equally importantly, to the general atmosphere in the home and to the level of care provided."

We saw further improvements had been made to the fixtures and fittings in the service. New external doors had been fitted, a new smoking shelter had been built, some bathrooms and bedrooms had been refurbished. People's bedrooms were personalised with photographs, furniture and ornaments.

Requires Improvement

Is the service caring?

Our findings

We asked one person if they liked living at Ainsworth Nursing Home. They responded, "Not really, there's nothing much to like, you just sit here and behave yourself." We asked another person if they felt staff were kind to them, they said "Ask another question" and would not elaborate. Two other people said that staff were kind. We also asked people if they felt staff members listened to them. One person told us 'no' and two people told us they did. Another person stated "They say tell me tomorrow."

Relatives we spoke with told us, "The kindness since the change has been wonderful. He's always nice and clean, I couldn't fault it", "I have never had cause to complain about the staff", "They are definitely very kind", "I think so", "Yes we have a lot of banter", "They listen to her and talk to her" and "Definitely, would not leave [relative] here if I wasn't happy." We also spoke to a visiting professional; they told us "Their attitude is fine. I have never seen staff treating people roughly. Sometimes residents have food on their cloths if I visit straight after meals."

Prior to our inspection we received a number of letters from relatives of people who used the service. One person told us, "The staff from management, office, care workers, maintenance, kitchen and domestics whom I have got to know really well, have always been very professional when attending to people's requirements. Also they have become like family. I feel I could count on anyone of them day or night and I would say it is my second home and life saviour." Another person told us, "All the staff at the home, from the manager to the cook and the handyman, are pleasant and caring and deserve credit for the way in which they have looked after [name of service user] over the last six years."

We asked staff members how they supported those people living with dementia. One staff member told us, "With compassion, patience and understanding. It's not their fault. It's not just a job." Another staff member told us, "Have a bit more time, patience and understanding."

At our previous two inspections we saw some of the language used by staff when writing care plans and recording notes in care files was negative and not respectful of people. During this inspection we found the same care plans in place containing negative comments. Another comment we saw described a person as on "Mithering for cigarettes." This was written by a qualified nurse and does not promote respectful attitudes amongst staff members.

We looked at the records relating to one staff meeting on the 23 February 2016. We saw that confidentiality, privacy and dignity had been discussed at length with the staff members. We asked people who used the service if they felt staff treated them with dignity and respect. Comments we received included "They're not bad", "Yes", "They're quite good", "They knock on my door and I close the bathroom door" and "They don't always knock, I've asked them to knock."

During our inspection it was necessary to speak to the manager and provider regarding the attitude of one staff member. We observed an occasion when they were singing and dancing loudly on the dementia unit. One person appeared to be enjoying this and became very vocal and excited. Another person also started

making noises, to which the staff member became patronising, saying "Oh yes, oh yes", despite not being able to understand the person. A nurse entered the lounge and asked the person to "Sshh." The staff member stated it was their fault, to which the nurse responded it was very noisy. The staff member then spoke to the person and told them to "Have a rest" and when the person continued, they stated "Enough" despite the staff member being the one to excite them. We also observed the staff member supporting people from the conservatory to the lounge. It was acknowledged that the conservatory was very warm, however when one person queried why they were being moved the staff member stated, "We know what's best for you." The expert by experience also found this person to be abrupt during the time they were interviewing them. This is not respectful of people and shows a lack of regard for others.

At 13:25pm during our lunchtime observations we noted that one person stood up from the table. We noticed their clothes were very wet. We told a staff member who responded "We can't mix toileting and feeding." We asked, "If he is wet he has to stay wet?" The staff member responded, "Yes, sorry." This person was taken to be changed at 13:50pm meaning they had been sat in their own urine for 25 minutes. Not only is this undignified it places the person at risk of their skin breaking down and becoming sore.

People who used the service were not always treated with dignity and respect. These matters are a continued breach of Regulation 10 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed other staff members who took time to sit and chat with people who were sat in the main lounge areas and attempt to involve them in colouring or dominoes. These staff were observed to be caring and kind in their interactions.

During our last inspection we observed a breach of confidentiality. A staff member was overheard discussing the care and treatment of a person with a relative. During this inspection we found all care records were stored in locked cabinets and only staff members had access to them. We did not see any instances where confidentiality was breached.

We asked staff members if they had received training in the end of life care. One staff member told us they had not, whilst another staff member told us, "I did the gold standard framework (GSF) in end of life a few years ago." We also asked how they ensure they met the needs of people at the end of their life. Comments we received included "The care plan or the family" and "We give them a dignified death. We ask the family, they know them better than us or an advocate."

We were given the end of life policy on the first day of our inspection. We were given a policy that made reference to another care service and were told this was a working document and saw evidence to show that staff had read and understood this. We discussed this with the manager and on the second day of our inspection we were given a new policy and procedure they had just developed.

There was nobody receiving end of life care on the day of our inspection. Care plans we looked at were old ones and needed to be re-written in the new format that was being developed by the manager.

During our inspection an advocate attended the service and was available for those people who wished to see them. We also noted on the notice board in the main reception area there were details of how to contact an advocate should anyone require one.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we saw some improvements had been made in relation to the opportunities for people to engage in meaningful activities. However, we found there was continued lack of opportunities to stimulate people living with dementia. We made a recommendation that the provider considered widening the expertise of the care staff to ensure that people are stimulated and engaged in activities as much as they wish each day.

During this inspection we were informed that the activities co-ordinator had changed positions and was now an assistant cook. The provider and manager told us they had employed a new activities co-ordinator and they were awaiting the relevant checks to be completed before they could commence employment. They also told us they had ensured extra staff members were on duty during the day to continue to provide activities. However we checked the rotas in place and found that between 16 May 2016 and 12 June 2016 there were only nine occasions when extra staff were available between 7am and 3pm.

We spoke with people who used the service to ask them what activities they undertook. Comments we received included, "I sleep", "I colour pictures in and play dominoes and I paint", "Nobody ever sits and talks to me" and "I go for a walk or watch television." We also spoke with relatives about the activities on offer. Comments we received included, "I have seen them playing with a ball", "[relative] can't do anything", "I think he walks about a lot, moves furniture and sits in rooms" and "[Relative] doesn't connect with people and won't join in activities. We try to stimulate him but he won't join in anymore."

One relative who wrote to us prior to our inspection told us, "Carers at the home engage with [name of service user], spend time with him and treat him with dignity and respect. He has recently shown an interest in dominoes and playing cards and, although his poor language skills makes communication difficult, his numeracy skills are better, and he is able to gain some enjoyment from taking part in these activities. We hope that staff will be able to build upon the range of activities on offer in the future as additional engagement and stimulation would be beneficial to residents."

Staff we spoke with about activities and engaging people told us, "We have an activities coordinator, but we do as much as we can" and "We play cards with them. We have an R.A.F. book and we have balls and building bricks."

We looked at the activities records for people who were accommodated on the dementia unit. Records showed that from the 13 May 2016 until the 3 June 2016 activities for one person involved ten days when all they had undertaken for the day was 'playing catch', one day when they had a hand massage, two days were they were singing, a day when they listened to music and a day when they walked around the unit. We spent time on the dementia unit and found a significant lack of stimulation for people. On one day of our inspection we noted the TV was on with a black screen, with a sign stating "press the red button" and no sound, there was no music on and five of the six people were asleep at 11am. Staff present on the unit did not make any attempt to engage people or offer an activity. We did not see evidence of dementia friendly resources or adaptations in the communal areas. This meant there were continued lost opportunities to

stimulate and relieve the boredom of people who used the service on a daily basis

On two of the three days of our inspection the weather was sunny and warm. We heard one person on the general unit (who was asked if she wanted to colour) state, "I am waiting to go out for a walk." The staff member did not respond to this request and walked away. We noted that the door to the garden was open on the general unit; however there was a chair placed blocking the exit. We asked the provider if people could go outside to enjoy the weather and were told "Yes as long as they have a staff member with them." We did not see anyone on the general unit outside in the garden during the three days of our inspection. Activities we saw on offer on the general unit consisted of colouring, dominoes and reading. We observed one person was asked if they wanted to colour, they responded "I have already done it once." We saw a staff member put a colouring book and pencils in front of another person and state "Do the colouring, yeah." This person just sat with the book and pencils in front of them, uninterested in colouring. We also noted that the television was on playing music on the radio and there was a radio on playing music from a different channel. This does not present as a calming and relaxing environment for people.

These matters are a continued breach of Regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's care and treatment was not designed to make sure it met all their needs.

We asked people who used the service if they had seen their care plan. Only one person told us they had seen it and commented "They review it on my circumstances."

At our previous two inspections we found care records did not contain accurate up to date information about people's needs and how they wished to be supported. During this inspection we examined the care records for eight people. We found some new care plans were in the process of being developed which contained more detailed information to direct staff. However, these were not a working document at the time of our inspection. The remainder of the care records in place continued to lack accurate up to date information as they were the same as our previous two inspections. For example, one person presented with behaviours that challenge. Care records we looked at did not provide sufficient information to direct staff on how to manage the behaviours that they presented with. Another person required the use of a sling. Their care plan made no reference to requiring a sling, which type of sling was to be used or if this was suitable to remain sat in all day.

This was a continued breach of regulation 17 (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care plans must be in place and should be accurate to ensure safe and effective care is provided in a consistent way.

Care records we looked at showed that people's needs had been assessed prior to moving into Ainsworth Nursing Home. We saw on the care records we looked at that a detailed assessment had been received from the commissioning team. This helped the service decide if the placement was suitable and if people's needs could be met by staff.

None of the people we spoke with were sure how to make a complaint. One person told us "I complained this morning not to shout at me, [name of staff member] shouted at me so I shouted back." We asked relatives if they had ever found the need to raise concerns. Comments we received included, "A long time ago. I think things have improved" and "I don't think so, I wasn't as happy previously before the change." Prior to our inspection we received a number of letters from relatives of people who used the service. One relative told us, "If I had any queries or minor problems with any aspect of [name of service user] management the problems were quickly sorted out by the staff and manager." Another relative told us, "At

no time have I had any concerns over his well-being or care that he is receiving. I cannot speak to highly of the care he receives for believe me if any problems did arise I would speak to the owner and if I was not satisfied with his answers I would find somewhere else for him to reside."

We spoke to relatives to ask if they were kept up to date with the care and treatment of their loved ones. They told us, "Yes the manager came and spoke to me last week about his medicines", "I come quite often" and "His sleeping patterns have changed."

We asked staff members how they were kept informed when people's needs changed. They told us, "Handover" and "Daily handover twice a day." One staff member stated, "Communication is a lot better now." We looked at a number of handover sheets and found these contained limited information about people, for example "Settled", "OK" and "No change." However on some occasions the night staff had given more detailed information such as how people had slept, if they had been to the toilet and if they had taken their prescribed medicines. If staff members are relying on these handovers sheets to inform them how people have presented then necessary information should be included.

We asked people who used the service if they were encouraged to make everyday choices. Comments we received included, "I get up and go to bed when I want and I pick my own clothes" and "I chose my own clothes, I get wakened in a morning for breakfast, but I go to bed when I want, sometimes they say no you can't have a lie in and you have to get up." Other people told us staff respected their choices.

We also asked staff members how they ensured people who used the service had choices. One staff member told us, "We ask them and their families, we know what's best for them, the families have told them. It is in their care plan." Another staff member told us, "We ask them first."

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in place. A registered manager had not been in place since 1 February 2016 when we cancelled the previous manager's registration with us. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The deputy manager was promoted to the position of manager and applied to CQC to register to become the registered manager. During the registration process she decided to withdraw her application as she felt she did not have the skills to take up the post, despite being appointed by the provider to be the manager of the home. Providers have a responsibility under Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; to ensure they employ a manager that is fit and proper and has the necessary skills, competence and experience to undertake the role. The provider has been in breach of the Health and Social Care Act regulations for over 12 months. Action plans have been submitted which on inspection have not been implemented, a manager appointed did not have the skills for the role and evidence gathered on this inspection shows that whilst some improvements are evident overall this is a service which does not deliver a good quality of care t people, supported by a well-trained and well managed staff team and manager.

A new manager had been employed and was in the process of applying to register with the CQC. They had been in post for three weeks on the day of our inspection.

During our inspection the manager provided us with a statement of purpose. We noted that this had been revised to include their own details; a copy was also available in the main reception. The day after we finished our inspection we checked our records and noted that the provider had not submitted a notification to inform us of the changes to the statement of purpose.

These matters are a breach of Regulation 12 (1) and (3) of the Health and Social Care Act 2008 (Registration) Regulations 2009 as the provider failed to notify us of changes.

On one personnel file we looked at we noted a letter from the Royal College of Nursing (RCN) in relation to a nurse where conditions had been placed on their registration. These conditions had been made by the Nursing and Midwifery Council (NMC) due to issues identified in their clinical practice with regards to the safe administration and management of people's medicines. We asked the provider what action had been taken to address the recommendations outlined in the letter.

We were told by the provider that the completion of a personal development plan (PDP), evidence of monthly supervisions and an assessment of competency had to be completed for the nurse with conditions placed on them, whilst they had taken place had not been recorded.

On examination of the supervision minutes we found information was vague and did not evidence that the nurse was able to demonstrate their knowledge and understanding of the procedures in place to ensure

safe administration of medicines. There was no information to demonstrate that a comprehensive competency assessment had been completed to assess the nurse's clinical skills, particularly in relation to medication practice. This type of evidence helps to demonstrate that where necessary staff have been assessed as having the qualities and skills needed to support people safely. We discussed our concerns with the provider and manager. We were told that further monitoring would be put in place to ensure the recommendations were fully met.

These matters are a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not regularly assess the skills and competence of staff to ensure their fitness.

During our previous two inspections we found that audits were not sufficiently robust to identify some of the issues we found during our inspection. During this inspection we found the same weekly audits were in place. These consisted of accidents, incidents, complaints, recruitment, hospital admissions, deaths and inductions and had not been completed since 17 April 2016. Service user finance audits had not been completed since 21 April 2016, weekly medicine audits had not been completed since 22 April 2016, bedroom audits had not been completed since 6 February 2016 and no care plan audits had been undertaken. The provider had failed to understand the importance of monitoring and assessing the service provided so that people were kept safe. This resulted in us making three further safeguarding alerts following this inspection.

The lack of robust and regular auditing meant that the service had no effective systems in place to continually monitor the service provided to ensure people received safe and effective care. This is a continued breach of Regulation 17 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager to show us their policies in relation to safeguarding, MCA, end of life, whistle-blowing, restraint and infection control. As mentioned in other domains, we were given policies that made reference to another care service. We spoke to the manager and provider regarding this who informed us they were working documents that staff were using them to guide them in their roles. However when we pointed out that they made reference to another care service they informed us they had yet to work through all the policies and procedures and had quickly put something in place as they had "Panicked." Therefore the policies and procedures in place on the day of our inspection were not relevant to the service. Until new policies and procedures were developed that were relevant and staff had read and understood them, there was limited guidance for staff.

This is a continued breach of Regulation 17 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff members and asked them how they gave people choices about their personal care. Comments we received included, "We don't have a bath on this side, they have at least one shower a week, some have two depending on continence" and "They have at least one shower a week, two or three get a shower every day. We always tell them and explain to them."

One person who used the service told us "I would like a shower every day, but it is up to them (staff members) when they can do it." Another person told us, "I was hoping to have a shower today, but I am going to the hospital. I might have one this afternoon."

We looked at the personal hygiene records for four people who used the service. We noted on one person's

records, "[name of service user] finds showers are soothing for her skin, particularly her legs which become flaky and itchy." Care records also showed that this person was incontinent. Personal hygiene records for this person showed from the period 1 March 2016 until 6 June 2016 they had received a total of 12 showers, despite informing us they wanted daily showers. The remaining days this person was given a wash. On the first day of our inspection, this person voluntarily showed and told the expert by experience of her sore toe. It was noted this was red, the skin on her foot was flaky and a malodour was noted. Care records and daily reports showed no mention of any skin checks that had been undertaken.

One person's personal hygiene records we looked at showed between the period 1 March 2016 until 6 June 2016 they had received a total of one shower. Another person's records showed they had received eleven showers during the same time frame and a third person's records showed they had gone 25 days without having a bath or shower. All these people were incontinent and required full support with toileting and hygiene needs. Records also showed that people's teeth and hair had not been washed or cleaned on a regular basis.

We looked at four re-positioning charts that were in place for those people who were at risk of developing pressure ulcers. We noted that all the charts were pre-printed with the times 08:00am, 10:00am, 12:00noon, 14:00pm and so on every two hours. We spoke with a care staff member about these times and asked if everyone was re-positioned at exactly these times. They stated "I know what you mean, no sometimes it might be ten past or quarter past the hour." We also noted that one person's records showed they had not been re-positioned at all during the night of 3 June 2016. Some records did not evidence where people where re-positioned to, for example their right side or left side, comments included "Re-positioned." Staff were not correctly recording the times that people were repositioned, where they were re-positioned and if they had been, thus placing them at risk of developing pressure ulcers. We noted that on the day of our inspection there was no one in the service with a pressure ulcer.

These matters are a continued breach of regulation 17 (1) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as records were not up to date, accurate and did not reflect the care and treatment being provided.

We asked people who used the service if they felt they could talk to the manager. Comments we received included, "No", "Yes but I don't know the new manager is" and "Yes". Not all the people who used the service knew who the new manager was.

Relatives we spoke to told us, "She hasn't introduced herself but yes" and "I think if there was an issue I would contact his son [relatives son] but there's never been an issue." Staff members we spoke with about the management team told us, "They are alright" and "We all get on well."

We asked staff members about the culture of the home. Comments we received included "At the moment we have got quite a few good ones (care staff). I feel part of it and we have a good laugh with the residents" and "I am happy most of the time. The staff get on." When asked if they felt able to approach the manager with concerns they told us, "I am not frightened of anybody, without a doubt I would report it and tell them as well" and "I would report concerns, she is very approachable."

One relative who wrote to us prior to our inspection commented, "Ainsworth has always had a calm and friendly atmosphere greatly contributing to the satisfaction of both residents and their families."

We found the manager was approachable during our inspection and was open and transparent throughout.

Prior to our inspection we received a number of letters from relatives of people who lived at Ainsworth Nursing Home. One relative commented, "This is the third nursing home that [service user] has stayed at and compared to the previous two I have found Ainsworth Nursing Home very friendly, homely and cheerful, where myself and my wife feel at ease. I go home with the confidence that [service user] would be safe and well cared for when I am not there." Other comments we received included, "I visit every day and have seen the improvements that have been made and still on-going" and "Since the inadequate report last year the manager and staff have worked very hard to improve the standard of care."

We asked relatives if they had the opportunity to comment on the service. They told us, "We have had questionnaires fairly regularly, at least once per year", "Yes quite regularly", "Yes about twice a year" and "Not long ago we had tick boxes." We saw no evidence that information from the surveys had been collated. This meant the service had not taken steps to assess and implement actions from the results of these.

We asked people who used the service if they had meetings and if anything changed as a result of these. Comments we received included, "Sometimes we have meetings but things don't change", "They have meetings and maybe it does (change), maybe it doesn't" and "They have meetings, sometime I go. They are generally every month. Sometimes things change, sometimes they don't."

Records we looked at showed that relatives were also invited to these meetings although one relative told us, "I don't go to residents meetings, if I have any concerns I have a word with the manager. If I wasn't happy I would move her to another home." Topics of discussion in service user meetings included CQC reports, staffing and cleanliness. However, we saw no evidence to show what things had changed as a result of these meetings.