Mr and Mrs J C Walsh

Ambleside

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 September 2018 and was unannounced.

Ambleside is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home specialised in the care of people who lived with dementia. It also provided a day care service.

Ambleside can accommodate 18 people in one adapted building. At the time of the inspection 15 people lived there. People were provided with single bedrooms with en-suite toilets and washing facilities. The home had two communal bathrooms; only one had been adapted to support assisted bathing. There was a dining room, front lounge and conservatory at the back. A passenger lift supported access to the upper floors and there was assisted wheelchair access to the building. Parking was available at the front of the building.

There was a registered manager in position. 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.

At our last inspection on 19 and 22 May 2017 we rated the service 'Requires Improvement'. People's care records had not always been maintained accurately in order to reflect their planned care, the care they received and decisions made on their behalf. Improvements were also needed to the provider's quality monitoring processes as these had not identified the above shortfalls. We asked the provider to complete an action plan.

During this inspection we found some improvements had been made but further improvements were needed and we again rated the service 'Requires Improvement' overall. This is the second time the service has been rated 'Requires Improvement'.

We found improvements had been made to people's care plans making them more detailed. However, we found shortfalls in other records, relating to people's care and the management of the service. For example, care monitoring records, accident and incident records and those used for quality monitoring purposes.

We also identified a lack of cleanliness, poor cleaning arrangements and poor maintenance of the premises. Quality monitoring systems were not effective. They had not sufficiently identified areas which required improvement. For example, relating to risks associated with ill-fitting floor coverings, general maintenance and a lack of cleanliness. The audits and checks used in this process had not always provided the registered provider with the correct information to identify where improvements were needed.

Where concerns were known to the registered manager, prompt and effective action had not been taken to ensure risks were managed and improvements made and sustained. In some areas the registered manager relied on other staffs' information and verbal feedback, regarding areas for improvement. They did not always have their own processes in place for following these up or carrying out their own checks.

A system for demonstrating that progress was being made on required actions and that on-going improvement was planned, was not in place. For example, actions for improvement did not then form a central improvement plan which could be worked on and collectively reviewed by the managers. However, a newly formed service improvement plan was sent to us following this inspection, showing us how and by when some areas for improvement were to be completed

People received support to take their medicines, but by not recording the specific time people were administered pain relief, put people at potential risk of medicine errors. We have made a recommendation about the recording of time-sensitive medicines.

Although some recruitment checks were carried out prior to staff starting work, these had not always been as robust as they could have been. We have made a recommendation about staff recruitment checks.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. However, where people who had not provided consent to live at Ambleside, and where people were not free to leave the home independently, there was no evidence to show that full processes under the Mental Capacity Act 2005 had taken place. We have made a recommendation about seeking current best practice in relation to the MCA and DoLS to ensure necessary regulations are met.

During the inspection we observed limited opportunities for people to take part in social and meaningful activities. There was evidence to suggest this had not always been the case however, and a new activities co-ordinator was due to start soon.

There was a lack of support to help people who lived with dementia to remain orientated to time, day, month and season. People did not always receive the care they needed to maintain their personal hygiene.

People's nutritional risks were addressed and people had a choice in what they ate and drank.
People had access to health care professionals when needed.

Staff had received training and support to carry out their roles. People and their visitors told us staff were caring, kind and respectful. People's relatives, and their representatives, where appropriate, could visit at any time and be actively involved in planning and reviewing people's care.

People's privacy and dignity was maintained. Staff knew the people they cared for well and could communicate with them effectively. People were supported to have a comfortable and dignified end of life. People's care plans gave staff guidance on how to meet their needs. These had been improved to contain more personalised information. They were reviewed and kept up to date.

People and visitors to the home could make a complaint or raise areas of dissatisfaction. Lessons had been learnt from concerns which had been raised and the home had been transparent in its investigations about these.

The views of relatives and other visitors to the home had been sought earlier in 2018 and questionnaires contained predominantly positive feedback about the service.

Three breaches against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified during this inspection.

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 always safe.

Alterations and improvements to the environment had not always been carried out promptly when risks to people had been identified.

A lack of general cleanliness put people at risk of potential infection.

People received support to take their medicines, although a lack of recording the time when people's pain relief was administered, put people at potential risk of receiving their next dose too soon.

There were enough staff to meet people's care needs. Staff recruitment checks were completed, but more robust checks, under certain circumstances, needed to be completed to ensure people were fully protected from those who may not be suitable.

There were arrangements in place to protect people from potential abuse and discrimination.

Is the service effective?

Requires Improvement

The service was not fully effective.

When people could not consent to live at the home, improvements were needed to how staff recorded that people's mental capacity was always fully assessed in relation to this, and, that best interests decision processes were fully completed and recorded.

People were supported to make simple daily choices and decisions.

Staff received training and support to carry out their tasks. Improvements were needed to ensure all staff understood how to complete people's daily care records accurately.

Risks to people's health were assessed. People were supported

to eat and drink and maintain their nutritional wellbeing.

People had access to health care professionals when needed.

Is the service caring?

Good

The service was caring.

People's care was delivered by staff who spoke to them in a kind and caring way.

People's privacy and dignity was maintained and people were treated with respect.

Relatives and other visitors, where appropriate, were kept informed about people's health and the care being provided to them. People's representatives were able to speak on behalf of them.

People's likes, dislikes and preferences were explored and their care, sometimes, provided in a way which took these into consideration.

People's diverse needs and preferences were understood, respected and met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was planned and reviewed with people's involvement, where possible, and the involvement of their representatives, where appropriate. However, in practice, people's personal care and social needs were not fully met.

There were arrangements in place for people and visitors to be able to raise a complaint and have this addressed.

Staff supported people to have a dignified and comfortable end of life.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's quality monitoring system had not always been effective in assessing, monitoring and improving the services provided to people and the arrangements which were designed to keep people safe.

Records pertaining to people's care and the quality monitoring system did not always provide accurate information. The views of people's relatives and other visitors to the home had been sought.	

Ambleside

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 10 and 11 September 2018 and was unannounced. It was carried out by two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case, experience of caring for someone with similar needs.

Prior to visiting the home, we reviewed the information we held about the service. This included notifications sent to us. Notifications are information about events and situations which have occurred, which the provider must legally inform us about. We used information from the Provider Information Return (PIR), submitted by the provider in June 2018, to help plan our inspection. This is information we require providers to send to us at least once annually. It gives some key information about the service, what the service does well and improvements they plan to make. We gathered the views of professionals who visited and from commissioners of the service.

During the inspection we spoke with six people who used the service and three relatives to gain their view of the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, quality assurance manager, operational manager, five care staff, a cook and a member of staff supporting activities.

We reviewed people's care records which included care plans and risk assessments. We reviewed records relating to the Mental Capacity Act, staff recruitment, accidents and incidents, activities, complaints, staff rosters, quality monitoring processes and visitors' feedback. We visited all bedrooms and other areas of the premises used by people and staff.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living in the home. One person said, "I do feel safe here as are my possessions."

After visiting all areas of the home, we found the environment not to be sufficiently maintained to support people's safety and welfare. For example, in several bedrooms there was ill-fitting floor covering. During our previous inspection in May 2017 we had observed temporary repairs to ripped areas of flooring and had discussed the 'rucking up' of some bedroom flooring. In May 2017 the registered manager had told us they were waiting for quotes and a suitable time to replace some of this flooring.

During this inspection we were told that some bedroom flooring had been changed since the last inspection but was "rucking up" again due to the beds being moved. The registered manager told us the carpet in all corridors was going to be changed as was the flooring in the conservatory and some bedrooms. They told us they had made enquiries about this, but as yet no flooring had been purchased and a date for completing this had not yet been planned.

We reviewed all recorded falls which had taken place in the home. This information told us there were people who lived at Ambleside who had experienced falls and who were at risk of falling again. Poorly fitted floor covering potentially increased this risk.

We observed other areas of poor maintenance in people's en-suites and in one toilet which one manager told us the maintenance person was due to address. Outside there were uneven paving slabs leading down to the garden but one manager said people did not use the main garden often and not alone. On the building itself, external facia boards and some windows were in a poor state of repair and decoration. We were informed builders were due to start work on some outside repairs imminently, but it was unclear what this included.

The environment and some equipment was not clean. We observed cobwebs, dusty items in bedrooms, an unclean bottom to a bath hoist and mould on the inside of the lids of people's water jugs. We were informed that one cleaner had been unreliable for some time and managers were looking for a replacement. We observed one of the home's 'bank' staff cleaning on the first day of the inspection. By the second day of the inspection one manager explained to us how people's water jugs, including the lid, would be appropriately cleaned moving forward. Cleaning records had only been maintained for carpet cleaning up until July 2018. One of the managers showed us a new template which they were developing for recording the general cleaning of the home.

We were told by one manager that the lack of hygiene and cleanliness had been discussed numerous times with the staff and they had been told this had to improve. On the second day there was an obvious improvement in the cleanliness and tidiness of the conservatory area; where most people sat. An infection control audit had been completed in February 2017 with a completed review date of 17 April 2018. There were no required actions recorded from this.

A cupboard containing cleaning products, one being bleach, had the key in the door. We were told this was the main cupboard for storing chemicals hazardous to health. This should have been kept secure in line with the Control of Substances Hazardous to Health Regulations 2002. When we asked why the key had been left in the lock we were told the cleaner was close by. The key was subsequently removed from the lock.

Appropriate alterations to the premises had not been made to address previously identified risks, for example, the floor coverings. Effective systems were not in place to ensure people lived in a well-maintained home where standards of cleanliness were always upheld.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative said, "The home could do with some refurbishment, it's sometimes run down." They did also say they usually found it to be clean.

Staff recruitment files showed that clearances with the Disclosure and Barring Service (DBS) had been obtained prior to staff working in the home. An 'enhanced clearance' had been sought which checked the member of staff against all police records as well as against the national list of people barred to work with vulnerable adults. References had been obtained but these were all 'character only' references; people who knew the member of staff personally. In one case the member of staff had not previously been employed, but in another they had previously worked in care, but no reference had been requested from this care provider. There was also no recorded evidence of previous employment history. There needed to be an improvement in the robustness of these checks in order to protect people from those who may not be suitable. Various competency checks had been completed with the member of staff with no professional reference and they had been found to be competent in their role.

We recommend that the service finds out more about current best practice in relation to obtaining information about staff's conduct in previous employment.

People received their prescribed medicines and the support they needed to take these. One person said, "My medicines are more or less on time. I trust the staff here. They know what they are doing." Another person said, "I've only got to ask if I want any pain killers." Medicines were stored securely. Safe arrangements were in place for the return to the pharmacy of medicines not used and the delivery of new stock. Medicines prescribed to be given 'as required' had additional guidance in place for the safe use of these.

The specific time of administration of pain relief medicines such as Paracetamol, known as time-sensitive medicines, was not recorded. Staff instead recorded 'Breakfast', 'Lunch', 'Tea-time' and 'Bed-time'. We discussed with the registered manager that it would be safer to record the specific time when administering these types of medicines so that staff could be sure that the safe and recommended time had elapsed between doses. The registered manager told us staff knew when the above times; 'breakfast', 'lunch' and so on were for people and that it was usually the same member of staff administering people's medicines throughout the day. This practice however, does not allow for potential changes in people's and staffs' daily routines and potentially meant people could receive time-sensitive medicines before they were actually due.

We recommend that the service consider current guidance on the recording of administration of time-sensitive medicines.

A combined audit and risk assessment had been completed on all window restrictors on 30 August 2018. This recorded that every window was restricted and all restrictors were satisfactory. We observed a non-proprietary form of window restrictor in place. We discussed this with a manager who explained, that based on the risk assessment they were satisfied that the current arrangements were adequate. When we raised concern about a non-restricted window which was on the second floor. The same manager told us this window was between two keypad protected doors and people did not go in this area unattended. This window however, was later restricted.

During the inspection we did not observe anyone not getting the support they needed. We did observe staff to be consistently busy with limited time to do anything else but their care tasks. People told us they thought there were enough staff on duty to help them and that staff came when they pressed their call bell or when they "shouted" for help. The registered manager told us there were enough staff deployed each day. When we asked a member of staff if they considered there to be enough care staff deployed they said, "We can get on if we have help. If we need help [name of registered manager] will help." The registered manager told us their role was to predominantly help deliver people's care and manage anything related to people's care and treatment. One person also told us the registered manager helped the care staff with people's care. One relative who visited on a regular basis and at different times said, "The staff are always visible. I have never been here when there have not been staff around."

The home employed a quality assurance manager and an operations manager who job shared a full-time position by working opposite days. The role of these managers was to support the general management of the home and to maintain people's care plans. A cook was employed to prepare breakfasts, cook lunches and prepare food for teatime. There was no kitchen assistant employed but the cook said, "I don't require one." Maintenance was carried out by a person employed to attend to these tasks when they were allocated to them.

Staff told us they knew what to do and who to contact if they observed or suspected any form of abuse or discrimination. Records showed that staffs' knowledge in this area was reviewed every six months. Staff completed safeguarding training when they first started work in the home. Senior managers liaised with the local county council's safeguarding team when needed to help safeguard people.

There were arrangements in place to ensure all equipment, utilities and main systems in the home were maintained safely. Service records and maintenance visits, by specialised contractors, were seen. The company responsible for assessing fire safety, carried out a fire safety review during the inspection. The fire risk assessment had been reviewed in June 2018; there had been no alterations to the building since its last review in 2016. The heating system and boilers had been checked in June 2018. Annual water samples were taken to check against the growth of Legionella. The last sample, taken in January 2018, was clear of any growth. Water temperatures were monitored and maintained at recommended temperatures to support the health of the water system.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Most people at Ambleside lived with dementia. We observed the principles of the act being followed, in that people were nevertheless supported to make simple decisions and choices about their care.

Managers had applied to the county council (the supervisory body) for DoLS in relation to one person. This person lived with dementia and had continually wanted to leave the home and return to their own home. We were told it would have been unsafe for this person to have done this and staff therefore had needed to prevent this from happening. In this case, the supervisory body had authorised DoLS without any additional conditions.

Managers told us they had not submitted any further applications as they had not considered any other people to be deprived of their liberty. They explained, if people asked to go out they would be supported to do so. People could receive visitors at any time and visitors could take their friend or relative out, if the person wanted to go. Managers also explained that any additional supervision or control was only ever in place to help manage risks, for example, falls or to manage potential risks arising from behaviours that challenge.

There were however, people living at Ambleside, who had not independently made the decision to live there and where they would be prevented to leave if they tried to do so for their safety and welfare. A decision for these people to remain at the home had been made on their behalf and for them to receive the care and treatment they required. However, there were no mental capacity assessments, evidencing that a full assessment of their mental capacity in relation to this decision had been completed. Managers told us they had discussed these people with the supervisory body and had been advised that an application for DoLS was not required. These discussions had not been recorded and neither had the staffs' rationale for thinking people were not deprived of their liberty been noted. These best interests decision making processes had not been recorded in any detail. Although a 'DoLS' care plan was in place, which was bespoke to the home and generic in format, it did not provide the detail required to show that all processes under the Mental Capacity Act 2005 had been followed in these people's cases.

We discussed this with managers during the inspection. They subsequently confirmed that DoLS applications had been forwarded to the supervisory body for these people. This information has not yet

been checked by us but will be in a future inspection.

We recommend the service seek advice and guidance from a reputable source on how best to record best interests discussions and decisions.

In relation to other aspects of people's care, where appropriate, people's mental capacity had been assessed and care plans recorded the care people received, in their best interests. Records also showed, that where appropriate, people's representatives had been consulted about the decisions made about people's care and treatment.

We were told a staff training record (a training matrix) as such was not kept. We therefore gathered evidence about staffs' training and support by reviewing several training attendance records, training certificates and individual staff competency assessments. The staff also told us they received training and support from managers. A mix of computer based training and face to face training had been provided. Records told us staff had received training, had completed competency assessments and discussed subjects such as safeguarding adults, basic life support (which the registered manager told us covered how to manage choking), safe moving and handling and dementia care. A member of staff also confirmed that they and others had received training on the MCA and DoLS. Fire drills, for example, were recorded when they took place and these stated that staff had known how to respond to the fire bells, which had included how to carry out an evacuation.

Records also showed that other areas of practical care had been discussed with staff. This included, delivery of personal care, management of Warfarin (blood thinning medicine), pressure ulcer prevention, falls prevention, "feeding" and the completion of care monitoring and cream charts. Managers provided staff with one to one support meetings so they could discuss their progress, training needs and any concerns about their development they may have. The registered manager also completed all mandatory training. They had also completed training in accountability and documentation in 2015.

We also gathered information about staff training which had been delivered by the Care Home Support Team (CHST – health care professionals who support care services with individual people's care and who provide some health care training). Commissioners of the service confirmed the CHST professionals had delivered training on nutrition and end of life care (EoL) in 2017.

Improvement was needed to ensure all staff understood how to complete people's daily care records accurately. One person required support from staff to re-position to protect their skin from pressure damage and we found their turning chart had not been completed correctly. We also found another person's food intake chart was not completed accurately. This meant managers could not always judge from people's daily records that they received the support they required.

In these cases, no harm had come to the people involved and both issues had been followed up during the inspection. The registered manager told us they had already discussed the issue of accurate record keeping with one of these staff members. In order to provide some additional training for staff, a request had already been made to the CHST for training on records relating to end of life care as well as accountability and documentation training. The registered manager was waiting for this request to be accepted.

People were supported to eat and drink and they were able to make choices around this. People said they liked the food and other comments included "I can have something different if I'm not hungry" and "I like the sandwiches and the chocolate rolls, they're easy to eat and you don't have to sit at the table." The cook kept information about people's likes and dislikes and confirmed that people were given a drink whenever they

wanted one. They were informed about any changes in people's weight or dietary needs so they could respond to these accordingly. Where people had problems maintaining their weight for example, their food was fortified with additional cream and cheese in order to provide them with extra calories. The cook was also aware of what texture people's foods needed to be to meet their needs. Three people were provided with pureed food to prevent choking.

People had access to health care professionals. A GP visited on a regular basis to review people's health needs and medicines. People also received visits from GPs in-between these planned visits, when they were poorly. The community nursing team visited when needed to attend to any wounds, to administer insulin when needed, the flu vaccine or administer particular end of life medicines.

Some people had been assessed by physiotherapists with regard to their mobility and their need for supportive equipment. We observed one person using a walking frame. A manager explained that this person had not really moved from their chair until a physiotherapist had started to visit and work with them. This person was now mobilising slowly again and making good progress. Speech and language therapists visited and assessed people with swallowing problems. Records showed that a chiropodist visited on a regular basis and people had been seen by a visiting optical service. We were told people were supported to access dental care when needed. Some people had been assessed and supported by mental health practitioners and dementia specialists.

Good

Is the service caring?

Our findings

We observed the staff to be caring and supportive towards people; speaking with them in a kind and respectful way. When asked if the staff were kind towards them and if they respected their privacy and dignity one person said, "I'm always helped to get washed and dressed in my room with the door closed." Another person said, "They are very helpful and kind." A third person said, "They're very attentive, pretty damn good actually." One relative told us their relative had "Loved it [living in the home] from the first day", they went on to say, "There is an easy-going atmosphere. They give [name] her dignity, ask her opinion first and have a joke with her. It's exactly the same whatever time you visit. Another relative said, "The staff are lovely, they're very caring."

Both these relatives confirmed they had been involved in helping to plan their relatives' care and that they were informed of any changes made to this or in their relatives' health. One relative said, "I'm impressed, there are updated care plans which I have been invited to read."
Relatives could visit at any time and felt they were made welcome by the staff.

We observed people's care to be provided to them in private. When people were asked if they wanted to use the toilet this was done quietly. One person had become incontinent of urine in one of the communal rooms and we observed a member of staff deal with this in a way which maintained the person's dignity. When people were supported to eat and drink this was done in an unrushed and caring way.

English was not some staffs' first language but the staff knew the people well and were able to communicate with them in a way the person could understand. We observed one member of staff speaking with one person, who because of the stage of their dementia, had difficulty understanding what was being asked of them. The person was also unable to verbally communicate back in a way which was easily understood. The member of staff approached the person with a smile and used hand gestures to support what they were verbally saying. The person was clearly relaxed in the staff member's company and responded by following them so they could attend to their needs.

We did not gather any evidence that staff had received specific training in equality and diversity, apart from one competency assessment in relation to this for one staff member. However, in practice staff treated people equally and were accepting of their diverse needs and preferences. The staff group itself was diverse and managers confirmed that any form of discrimination in the home was not tolerated.

Some people preferred to remain in their bedrooms and we observed that everyone's bedroom door was kept closed. This practice was in place for fire safety reasons as the doors did not have automatic closures attached. We asked people if they felt isolated and if the staff visited them. One person told us they preferred their door to be closed, they said, "I like it closed, it's nice and quiet." However, two people told us they would like their door to be open but had never been given the option. We observed one person asking to have their door open and being told this was not possible as it was a "fire risk". Two people said, "The staff pop in to see me" and "I see the staff every now and again." We discussed with the registered manager, the issue of people potentially feeling isolated. They later told us they would check with the fire officer if

automatic door closures were an option for those who preferred their doors to be open. They would then look at installing some.

Requires Improvement

Is the service responsive?

Our findings

The main activity co-ordinator had left working at the home the week before this inspection. One member of staff said, "She was very good." A newly recruited activity co-ordinator was waiting for recruitment checks to clear. They visited the home on the second day to meet us. They also brought in their pet dog to introduce to people.

A relative told us they had raised concerns about there needing to be more activity opportunities for their relative and told us the previous activity co-ordinator had responded to this. They had found an activity that their relative enjoyed and had supported them to do this. We saw this person doing this activity during the inspection. Another relative said, "I have seen people singing, dancing, using musical instruments, doing jigsaws and putting plants into pots outside." They also said, "[Name of previous activity co-ordinator] was very good." This relative was unaware this member of staff had left; we informed them that another co-ordinator was due to start soon. One manager showed us a gazebo outside, just off the conservatory, where people had enjoyed sitting during the warm weather.

We found improvements were needed to ensure all people had a stimulating and meaningful day and were provided with appropriate support to engage in activities they enjoyed. During the inspection we did not consistently observe people being provided with many opportunities to take part in social activities. We did observe some people, being supported on a one to one basis to take part in an activity which was meaningful to them, by a member of staff who carried out this role between 09:00 hrs and 12:00 hrs, two days a week. One person had a visitor with them who was going through pictures in a book and keeping them interested and in conversation.

One person in the afternoon said, "I'm fed up with this place, there is nothing to do" and another person told us it was "boring" but also said, "They [the staff] try to please me." When we met this person, the television had been put on for them but they could not hear it.

During one afternoon, we sat in the conservatory for a period of time, to see what people experienced. We observed, when sitting there, that the view of the large garden and its wildlife was totally obscured by yellow coloured net curtains at each window. One manager told us the people had chosen these, but this limited people's view to the inside of the conservatory and the person opposite them. We also observed there to be no clock or reminder board telling people living with dementia what the day, date and month was. There were no other items of interest around for people living with dementia to engage in. There were two book cases one end of the room which we were told did not contain books with large print for people who had trouble with their eyesight.

Several people were either asleep or appeared disengaged with their surroundings. A member of staff came in and asked one person if they played dominos. The dominos were taken to them and the person asked how the game was played. The member of staff said they did not know and the dominos were put back. We later learnt from this person that they had poor eye sight and they could not see the dominos. This person told us they enjoyed listening to audio stories as well as the local news. The member of staff attempted to

organise the equipment for them to do this, but found there were no headphones. They were going to ask the person's relative to organise these. People were therefore not always provided with the individualised support they needed to take part in these activities.

People did not always receive the support they needed to maintain their personal hygiene. One relative told us they had seen staff previously cleaning their relative's teeth. However, we found
there was a lack of cleanliness with regard to people's oral hygiene. Throughout the inspection we observed several people's teeth to be in need of cleaning. We therefore looked to see where their toothbrushes were kept and to see if oral risk assessments were completed. We found numerous people's toothbrushes, clean and dirty, stored loose in unclean containers or with other personal hygiene items. Oral risk assessments were not used as is best practice, but there was brief reference to people's oral hygiene needs in their personal hygiene care plan. A manager told us some people were "difficult" to support in this area however, care plans did not detail how these people should then be supported.

We found one person's feet to be dirty between their toes despite the fact they said they were supported to have a shower on a regular basis. This person's personal hygiene care plan stated that they were to have a shower. Care records showed they had been provided with personal hygiene care but clearly, between their toes, had not been washed.

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

One person's family paid for additional one to one care on three days of the week because they wanted their relative to have this level of support. This was delivered by someone who worked in the home and who had built up a good rapport with the person and was able to deliver their personal care.

People's care had been planned in relation to their falls risk. We reviewed the falls assessments for people who had fallen in the preceding three months to the inspection. These had been reviewed with most not showing an increase in the level of risk. Relevant care plan reviews recorded any changes in care that had been made at the time. In one person's case treatment from a physiotherapist had supported progress with their mobility.

People's care plans gave staff information about their care needs and how to meet these, apart from their oral care. Care plans were personalised by recording people's likes, dislikes, preferences and what could cause people to become upset. One person had religious beliefs and other preferences so staff had asked them to write their own care plan. This person was able to do this and staff had felt that this would help them [the staff] to fully understand how the person wanted to be supported with these.

Relatives told us they knew how to make a complaint if they needed to. The provider's complaint procedure was on the home's noticeboard for reference. People were not able to speak with us about how they may make a complaint but they told us they had never had to. We were told that only "formal complaints", according to the registered manager, those received in writing, were recorded in the complaints file. We reviewed these with the registered manager. These had been safeguarding related concerns raised by professionals but which had been investigated by the registered manager. Lessons had been learnt from the issues raised in these. We were subsequently told that all complaints and all areas of dissatisfaction would be recorded in the file, along with the action taken to address these, in the future. This would make it easier for the home to demonstrate how it responded to all information received.

People received end of life care in accordance with their wishes. Managers told us the staff gathered specific

information about people's end of life preferences and wishes to ensure they could meet these at the appropriate time. The home was reviewing its documentation for end of life care to ensure it was in line with Gloucestershire's End of Life Pathway of care. Staff worked with local health care professionals to ensure people remained in the care home, if this was their wish, and to ensure they had a peaceful and comfortable death. One relative told us they had been able to speak, on behalf of their relative, with the staff, about their relative's end of life wishes and funeral plan.

Requires Improvement

Is the service well-led?

Our findings

The home was managed by two managers and the registered manager who shared responsibility for different areas of the home's governance. The overall decision making and responsibility sat with the registered manager. Any action required for general improvement or which were identified by the quality manager or operations manager, from their auditing or checks, was handed over verbally to the registered manager. Decisions about how and when these would be met were made and organised by the registered manager. We found this system had not always been effective in identifying and acting on actions which needed to be addressed promptly to ensure people's safety and wellbeing and in ensuring on-going improvement was achieved.

We reviewed a large quality monitoring file containing many monitoring checks and audit forms which sometimes did not give full detail about what was being monitored, the date of monitoring and what if any, were areas for improvement. Many of the records appeared to be purely an aid-memoir for the registered manager as opposed to an actual audit. For example, one form recorded if a Malnutrition Universal Screening Tool (MUST) had been completed for people and what their score was. This did not go on to audit if these scores were correct and if the correct care action was in place. The same was seen for pressure ulcers. The record only recorded if people had a pressure ulcer or not, it was not recorded whether appropriate action was being taken to manage any skin concerns or prevent pressure ulcers developing. No pressure ulcer check had been recorded past July 2018. We asked the registered manager if anyone had a pressure ulcer and we were told they had not.

We were concerned that where audits and checks had been completed, these were not always effective in supporting the provider to independently identify shortfalls and drive improvement. For example, there were no action plans or a central action plan outlining actions for improvement and when these would be completed. There was no collective system which gave managers a plan for addressing areas for improvement and on-going continuous improvement. For example, there was no information to tell us that the issues identified during the inspection had already been identified by managers and there were plans in place to address these. We were told for example, that staff had been spoken with about improving their hygiene practices and records and that the flooring in people's bedrooms was going to be improved, but none of these had been successfully resolved at the time of the inspection. In fact, the on-going issues with the floor coverings had been identified by us in the last inspection in May 2017.

To help explain our concerns about the ineffective quality monitoring system and the accuracy of the records used for this we compared, with the managers, the recorded findings of a health and safety check, called a risk assessment, which had been completed in August 2018, with what we found in one bedroom. The poor maintenance and health and safety issues seen in this bedroom, as well as other bedrooms, were not reflected on this quality check. The assessment had recorded all areas on the check, in all rooms, as not needing any action for improvement. The registered manager appeared to Inspectors to be unaware of the disconnect between the recorded check and what was in place and needing to be addressed.

There was similarly no effective system in place to monitor whether people received their personal care as

required and were supported to maintain their personal hygiene on an on-going basis to an acceptable standard.

Accident and incident monitoring systems were not operated effectively. The number of accidents and incidents were recorded, but we found records for these were incomplete. For example, missing information included what the actual accident or incident had been, the time it took place and the date it happened. One of the reasons for this was that one of the two different forms being used to record these did not ask what the incident/accident was.

These records had been audited, in respect of the number of falls per month, which had then been recorded. This process did not go on to show that trends and patterns were looked for and identified. The standard of record keeping would have made this difficult to do. The action seen recorded, in response to nearly all accidents (falls) was "Needs to be monitored closely". When reviewing the number of unwitnessed falls recorded for the month of August, this had obviously not been an effective action. One person, for example, had fallen twice and on each occasion had sustained injuries which needed hospital treatment.

The information gathered about falls during the auditing process, did not show that the circumstances behind each fall had been fully investigated and if the strategies in place were appropriate and effective to prevent recurrences. The system had clearly not been effective in preventing one person from falling twice. The recorded action following this person's first fall, did not show that a constructive or supportive approach had been taken towards risk managing their falls. A comment from the registered manager, on the accident form, said "[Name] cannot fall down again, the 3rd staff [we presume this meant 3rd member of staff on duty] will monitor [name], any fall, you [the staff] will be disciplined" and "Staff need to sit with person at all times." The first statement was not appropriate to be recorded on a person's record of care and the second comment did not go onto state how care staff would sit with this person "at all times" without this having an impact on other people's care.

Records were not always effectively maintained. Records relating to staff recruitment, accidents and incidents, quality monitoring processes, cleaning and records relating to decisions made on behalf of people, were not sufficiently detailed or maintained enough to demonstrate current legislation, guidance and best practice. When discussing these records and areas of shortfall, with the registered manager, they had no comment to make about this. Inspectors were left with the impression that the registered manager was unaware there was a problem with their records.

The overall systems in place to monitor the quality of care, people's safety and the services provided to people, were not sufficiently effective to always result in improvement to the service. Records relating to the management of the service were not always accurate or detailed enough to provide a true audit trail of both the findings or improvement actions planned or already taken.

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

Some quality checks were effective in maintaining good practice. For example, a weekly medicines check was seen completed. This showed that various checks on the medicine system and its records had been undertaken to ensure the system was safe and people's medicine administration records were being completed. The form in the folder had no date on it but recorded "no discrepancies". We were told the last check was completed on 9 Sept 2018 with no required actions identified.

During discussion about shortfalls in the quality monitoring system one manager produced a template for

'service improvement plan', which they wanted to introduce. During the inspection we fed back our inspection findings and requested that the registered manager forward us an action plan telling us how they intended to start making improvements to the service. This information was subsequently sent to us on their new service improvement plan template. This clearly recorded some areas for improvement, the action required, who was responsible for completing this and by when.

The views of visitors to the home had been sought in July 2018 by using questionnaires. Comments had included "Always very helpful and friendly" and "So impressed with the way he has been looked after, how kind and patient staff have been and how every effort has been made to keep me up dated." A tick box format was used to indicate for example, if visitors thought the home was clean. All 15 questionnaires returned referred to the home being kept clean and activities being provided. There were no recorded actions for proposed improvement from this survey.

Questionnaires for staff had also been distributed. All had been completed with positive comments. We observed that these questionnaires were not anonymous but had staffs' names recorded on them. Two care staff said, "I like it here" and "It's a happy home." Inspectors observed a caring culture where staff were well meaning and where staff and managers very much worked together as one team.

Training records recorded that the two managers and registered manager kept their knowledge up dated. Their knowledge when discussing areas of regulation and legislation was good throughout the inspection. Appropriate notifications had been forwarded to the CQC as required by law. The last rating awarded to the home, by the CQC, was on display in the reception area by way of a copy of the previous inspection report.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment provided to people did not always meet their individual needs. Regulation 9 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment were not always kept clean and properly maintained. The level of cleanliness was not sufficient to protect people from potential risks arising from this. Regulation 15 (1) (a) (c) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place were not sufficiently effective to fully assess, monitor and improve the quality and risk of services provided to people. Quality monitoring systems did not always effectively monitor and mitigate risks relating to people's health and safety. Regulation 17 (1) (2) (a) (b).

Records relating to people's care and the management of the service were not always accurately maintained.

Regulation 17 (2) (c) (d)