

## Archmore Care Services Ltd

# Ashdown Nursing Home

### Inspection report

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### Ratings

#### Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Inadequate



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



### Overall summary

The inspection took place on 6 and 8 January 2016 and was unannounced.

The provider had taken ownership of the home in September 2015, they explained to us that they had been left in a difficult predicament by the previous provider and recognised that the home and the care provided needed significant improvement. The registered manager had left in October 2015 and the home had been without a registered manager for three months. 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. The provider had recruited a new manager as well as a deputy manager, who have since left employment.

The overall rating for Ashdown Nursing Home is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

# Summary of findings

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Ashdown Nursing Home is located in Worthing. It is registered to accommodate a maximum of forty people, as some of the rooms were large enough for dual occupancy. However rooms had been converted and were single occupancy, therefore the provider was only able to accommodate a maximum of thirty-one people. At the time of our inspection there were twenty-nine people living in the home. The home is for people living with dementia, some of whom have complex health needs and who may require nursing support. The home itself is a large detached property spread over two floors. People had their own rooms and had access to shared, communal bathrooms. There were two lounges and a dining area. There were plans in place to extend the dining area to provide more space for people to use. There was a garden that was in the process of being landscaped with a summer house that people could use during the summer months.

There had been changes in the staff team, several members of staff had left the home, yet despite the use of agency staff there were insufficient levels and

inappropriate deployment of staff during peak periods to meet people's personalised and individual care needs. For example, due to there being inadequate staffing levels, one person, who preferred to be supported to get up and have their breakfast earlier in the morning, was supported to get up much later than they wished and was still eating their breakfast half an hour before their lunch was served. Staff confirmed this was the case, one member of staff told us "There are not enough staff. We are not finishing personal care and getting people up until about 12:00pm."

Risk assessments had been undertaken, however there was not always sufficient guidance for staff and these were not always implemented or sufficiently monitored. Observations of care practices raised concerns over people's safety when they were supported with moving and positioning and receiving pressure area care. People who were at risk of malnutrition had been assessed, however suitable measures had not been followed to ensure that appropriate actions were taken in regards to this. For example, care records for five out of the ten people that we looked at showed that since the provider had taken ownership of the home they had lost significant amounts of weight. This had not been recognised and they had not been referred to external healthcare professionals. People were not supported to maintain adequate nutrition and hydration. People had a poor dining experience and they were not supported appropriately to enable them to have sufficient amounts to eat and drink.

The level of staffing to meet people's individual needs, the implementation and monitoring of risk assessments, weight loss for people who had been assessed as being at risk of malnutrition and the practice of staff in relation to moving and positioning were areas of concern.

Accidents and incidents had been recorded but there were insufficient mechanisms in place to monitor these to identify trends and aid prevention. Measures to minimise the risk of cross contamination had been taken however observations of poor practice in relation to infection control raised concerns. These are areas in need of improvement.

People were supported by staff who lacked the experience, skills and knowledge to support them according to their needs. Relatives were concerned over staff's experience and skills and one member of staff told

# Summary of findings

us “The staff don’t really know anything about dementia care.” There was insufficient supervision, support or training for staff to provide them with the skills necessary to meet people’s needs.

The provider had taken some measures to ensure that people were asked for their consent and were not deprived of their liberty unlawfully. However, for people who required the use of bed rails and who needed to have their medicines administered covertly, measures hadn’t been taken to ensure that relevant people were consulted to give lawful consent for their use.

The skills and knowledge of staff, as well as the lack of processes to gain people’s consent were areas of concern.

Observations showed that people were not treated respectfully. One person told us “I can tell when people don’t care.” People were not always appropriately supported to maintain their continence or their personal hygiene. Relatives were concerned that their loved ones were not receiving the support that they needed. One relative told us “My relative never gets supported to use the toilet, the staff are told that they have to use their pads. I came in the other day and my relative had a blanket over them, I pulled it back and their legs were soaking wet.”

People were at risk of social isolation, their personalised and individual needs were not met and there was a lack of stimulation for people. One person confirmed this and told us “It’s a bit boring, I don’t know what I’m doing today, I don’t get out.”

The lack of personalised care to meet people’s needs and ensure they were treated respectfully and their dignity maintained was an area of concern.

There was a lack of quality monitoring processes and as a result the provider had failed to identify when people’s care needs were not being met. For example, people who had been assessed as being at risk of malnutrition had their weights and food and fluid intake monitored. However, the provider had not ensured that the results of these were reviewed or analysed. They had failed to identify that some people had lost significant amounts of weight and therefore had not taken the necessary action to ensure people’s safety.

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

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The home was not safe.

People were not adequately protected from abuse, harm or discrimination. Their human rights were not always promoted. There were insufficient staff to meet people's individual needs.

People were assessed to identify risk to their health. However there was insufficient monitoring of people's conditions and appropriate action was not taken in relation to the risk that was posed.

People received their medicines on time. There were safe systems in place for their administration, storage and disposal.

Inadequate



### Is the service effective?

The home was not effective.

Staff lacked the skills, knowledge and support to enable them to meet people's needs and provide effective care.

People were not asked for their consent before being supported. Relevant people were not involved in the decision making process when people lacked the capacity to give their consent.

People were not supported to eat and drink sufficient quantities to maintain their health.

Inadequate



### Is the service caring?

The home was not caring.

People were supported by staff who did not spend time getting to know their needs and preferences and caring relationships were not developed.

People were not treated with dignity, their privacy and rights were not respected.

People were not consistently involved in decisions or able to express their views and wishes about their care and treatment.

Inadequate



### Is the service responsive?

The home was not responsive.

People did not receive person-centred care that met their individual needs. There was a lack of stimulation and interaction with people and some people were at risk of social isolation.

People had access to a complaints policy, complaints were investigated and the provider took action in response to people's concerns.

Inadequate



### Is the service well-led?

The home was not well-led.

Inadequate



# Summary of findings

The home did not have a positive culture that ensured that people were treated as individuals.

There was a lack of strong leadership, management and strategic oversight of the home.

There was not a robust quality assurance process to identify the shortfalls in the care provided.

# Ashdown 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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 6 and 8 January 2016 and was unannounced. The inspection was brought forward due to information of concern that we had received. On the first day of the inspection, the inspection team consisted of four inspectors. On the second day of the inspection the inspection team consisted of two inspectors and an inspection manager. During the inspection, we spoke with seven people who lived at the home, eight relatives, twelve care staff and the providers.

The providers had taken ownership of the home in September 2015, they explained to us that they had been left in a difficult predicament by the previous provider and recognised that the home, and the care provided, needed significant improvement. The registered manager had left in October 2015 and the home had been without a registered manager for three months. A new manager had been recruited, who has since left employment.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were responding quickly to information and concerns that had been raised with us. We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at ten care plans and risk assessments along with other relevant documentation to support our findings.

This was the first inspection since the provider had taken ownership of the home.

# Is the service safe?

## Our findings

Observations of the level of staffing during peak periods, moving and positioning practice, pressure area care and the monitoring and assessment of risk for people's nutrition and hydration raised concerns over people's safety. Relatives provided mixed feedback regarding the safety of their loved ones, some relatives felt the care was safe whilst others had concerns. One relative told us "Yes, they're safe I'd say." However, this same relative felt that people were asked to stay in the communal lounge all day so that they were visible to staff and their safety assured.

Staffing levels were inadequate and did not allow for people to receive safe, personalised and individual care. There were six members of care staff and one registered nurse on shift during the day. At night there were three members of care staff and one registered nurse. The manager and records confirmed that this was a consistent level of staffing. A dependency tool was used to assess the person's needs in relation to the type of support they needed and the level of staffing required to meet their needs. However, this was not effective.

For example, there were insufficient staff during peak hours and they were not appropriately deployed to meet people's care needs. Observations showed that one person was still being supported with their personal hygiene and eating their breakfast half an hour before their lunch was served. The person was sitting in the lounge, they were visibly low in mood and a relative who was visiting asked the person if they were okay. The person commented that they were waiting for their breakfast and for a cup of tea. Care records for this person showed that the person preferred to get out of bed and have breakfast between 8:30am and 9:00am. This person was still in bed at 10:30am and only when the relative asked staff to get the person their breakfast did they eventually have this at 11:50am. The same person was then given their lunch at 12:30pm.

There had been changes in the staff team and several members of staff had recently left. The provider had ensured that agency staff were used to ensure that staffing levels were consistent. However, staff confirmed that there wasn't enough staff to support people according to their needs. One member of staff told us "We are really short staffed. We're getting people up at 11:00am and giving them breakfast when lunch is at 12:30pm." Another member of staff told us "There are not enough staff. We are

not finishing personal care and getting people up until about 12:00pm." Insufficient staffing levels during peak periods and the inappropriate deployment of staff had a direct impact on the quality of care provided to people.

### **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The provider had taken measures to ensure that each person was assessed in relation to risk, these reviewed a person's safety in regards to moving and positioning, their nutrition and susceptibility to developing wounds. Assessments for moving and positioning were reviewed regularly by nursing staff and changes made as a result. For example, one person's care plan showed that due to changes in the person's mobility they now required the use of a hoist.

However despite risk assessments being in place, observations of practice raised concerns around staff following these assessments and as a result people's health and safety was at risk. People were not supported safely when being assisted to move and position. Observations showed that people were being supported by staff who appeared not to have the relevant skills and knowledge to undertake this part of their role in a safe manner. One person was assisted to have a shower in a bathroom which was located in another part of the home to their bedroom. Observations of this person being assisted from the bathroom to their room showed that the person was transferred on a shower chair. A shower chair is a piece of equipment that is used to support a person to sit whilst having a shower if they are unable to stand unaided and is not designed for moving people around safely over longer distances.

This person was transferred in the shower chair for approximately 30 metres, the person was not secure, their feet were not elevated to avoid injury, they were wet from their shower, had minimal clothing on and a towel over their head. They were clearly distressed, upset and confused. Care plan records stated that this person should be informed about staff's actions as they could become anxious. Also that staff should offer reassurance throughout the support provided, staff did not do this and the person did not appear to feel safe. There was a ramp to another floor of the home and the person almost fell out of the shower chair whilst staff attempted to push the chair up the ramp. The person was left on the shower chair, in their

## Is the service safe?

room, with the door open, in full view of anyone who might be passing. The person had to wait an unreasonable amount of time whilst another member of staff arrived to assist the staff member to use a hoist. Care plan records for this person stated that they were assessed as high risk in regards to their mobility and moving and positioning. It advised that the person needed two members of staff to assist them and that a hoist should be used for transfers. It stated that the person was unable to bear their own weight, however there was no guidance of how the person should be supported to travel from one area to another.

Another person was supported by two members of staff to move from their armchair to a wheelchair. Care records for this person stated that the person is able to weight-bear and that staff should offer assistance to enable the person to transfer to the wheelchair. However, one of the members of staff was observed standing in front of the person and whilst they were reclining in the chair they placed their arms around the person and lifted them out of the chair, spinning them around into the wheelchair. This is an unsafe way to assist someone to move from one position to another and could lead to injury. The person was clearly disorientated, the staff member had not offered any explanation or reassurance to the person whilst supporting the person in an unsafe way. The person was then assisted to move in the wheelchair to their room, their feet were not supported on foot plates and therefore there was further risk of an injury occurring.

We observed an incident relating to poor manual handling which resulted in an injury. An incident occurred when another person was being supported to move from their chair to a wheelchair. The member of staff demonstrated good practice by staying with the person as they were slipping out of their chair, they offered reassurance and explained that they would support them to go to their room as this is what the person had indicated. Two members of staff then assisted the person to move from their chair to the wheelchair. Care records for this person stated that they could mobilise independently, but had become increasingly unsteady on their feet in recent months and required assistance from one member of staff. Staff undertook an unsafe procedure by placing their arms underneath the person's arms and when they were in a reclining position, assisted them to stand. This is known as a 'drag' lift. The 'drag' lift is any method of handling where the care worker(s) places a hand or arm under the person's armpit. Use of this lift can result to damage of the spine,

shoulders, wrist and knees. For the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Risk of fractures to the bone of the upper arm (humerus) and dislocation of the shoulder is also a possibility. The Royal College of Nursing provided the following guidance about the use of this lift technique 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out.' As the person appeared to be unprepared for this manoeuvre they were unsteady on their feet and sustained an injury to their leg as a result.

Observations showed that three people had ulcerations on their legs, one person's bandages were visually very soiled and stained. Records showed that these had not been changed for four days. The person had been assessed by a Tissue Viability Nurse (TVN) who had provided advice to staff identifying the type of treatment and the frequency that dressings needed to be changed. It had been recommended that the person's legs be washed every day with a specific cream and that dressings be applied to the ulcerated areas as well as being fully bandaged from the knee to the toe. A wound and tissue viability care plan had been devised as a result of this advice. However this did not fully comply with the advice given, it stated that the dressings should be changed on alternate days. There was no mention of washing the leg with the specific cream and records showed that the dressing had been changed less frequently than both the advice from the TVN and the wound and tissue viability care plan stated. For example, in December records showed that the person did not have their dressings changed for a period of five days. The tissue viability care plan for this person also advised staff to encourage the person to elevate their legs to promote circulation and aid healing, however observations showed that this person did not have their legs elevated, nor was it observed that they were encouraged to do so, during both days of our inspection.

One person who had a pressure ulcer for over five months, had been graded using the European Pressure Ulcer Advisory Panel (EPUAP) grading system and had been graded as having a category four pressure ulcer. This means that there is a full thickness tissue loss with exposed bone, tendon or muscle. This person had been referred to the TVN who had recommended treatment and the use of a pressure relieving cushion. The National Institute for Health and Care Excellence (NICE) guidance for pressure area care suggests that the seating needs of adults who have a

## Is the service safe?

pressure ulcer and are sitting for prolonged periods should be considered. Observations showed that this person was sitting in their chair for the entire day. They were calling out to staff and each time the person attempted to stand they were told to sit down. One member of staff told us “They sit in those chairs all day until they go to bed, no wonder they get pressure sores.” The only time the person was supported to change position out of the chair was when staff assisted the person to manage their continence needs. NICE suggests that people who are sitting for prolonged periods and who have pressure ulcers should use a pressure relieving device such as a specialised cushion. The person was sitting in an armchair with no pressure relieving cushion, despite this being recommended by the TVN. Therefore the person was at risk of further tissue breakdown as appropriate wound care had not been provided.

Care records for people who had been assessed as being at risk of malnutrition showed that they had been weighed each month and their food and fluids monitored. For people who had refused food, records had been completed to document this. However neither the records for people’s weights nor their food and fluid intake had been reviewed or analysed to respond to significant changes. Records for ten people were looked at, these showed that prior to the new provider taking ownership of the home they had either sustained their weight or it had increased. Since the provider had taken ownership of the home in September 2015 five people out of the ten had lost significant amounts of weight. One person had lost almost eight kilograms within a three month period and another two people had lost almost six kilograms within the same time frame. This showed that these people were at risk of being malnourished. Staff confirmed that this had not been recognised nor appropriate action taken, such as the fortifying of meals to increase the person’s calorie intake or a referral to a dietician or speech and language therapist (SALT) for advice.

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that nutrition support should be considered for people with a low BMI and who have had unintentional weight loss of more than 5% of their body weight over a three-six month period. The provider had taken some measures to ensure people had access to nutritional supplements. However, observations showed that for one person this was left at the end of a table, out of the person’s reach. The person did not take their

supplement and this was taken away by staff. Relatives consistently feedback that people’s nutrition and hydration needs were not being met. One relative told us “I’m worried that my relative is not getting enough to drink. There’s rarely any water or a jug in their room. I came into their room and there was a ‘fortisip’ (food supplement) at the end of the bed, unopened on the table, with an upturned glass next to it. It would be impossible for my relative to open this and pour it them self, They’re not getting enough fluids.” Another relative told us they felt they had to visit every day as they were not confident that their relative would get enough fluids if they didn’t.

Following the first day of the inspection the provider had taken measures to ensure that people who were at risk of malnutrition were monitored more effectively. However one person who had lost almost six kilograms over a three month period was not included in this monitoring and the provider had not taken further measures to ensure people received appropriate care to ensure their health. For example, referrals to SALT and dietitians had not taken place.

People were not safe when being supported with moving and positioning or in relation to pressure area care. People who had been assessed as being at risk of malnutrition were not sufficiently monitored and did not receive adequate support to maintain their nutrition and hydration and as a result they were at risk of being malnourished.

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

The home was generally clean, there were safe systems in place for the disposal of waste and staff were observed wearing personal protective equipment such as disposable gloves and aprons. However after one incident where a person sustained a cut to their leg, staff failed to notice that there was a small pool of blood on the floor. After a period of observation, an inspector intervened and asked staff to clean the area. A member of staff was then observed cleaning the area with a dry wipe, without anti-bacterial chemicals and with no gloves. This is an area of practice in need of improvement to help prevent cross infection.

The majority of care staff had not received training in safeguarding adults at risk. Observations of people raised concerns over people’s safety and following our inspection safeguarding alerts were made to the Local Authority. The

## Is the service safe?

provider had a safeguarding adults and a whistleblowing policy in place and had an awareness of safeguarding adults. They had made referrals for some people to ensure their safety was maintained. However, people were not cared for in a way that protected them from being discriminated against due to their vulnerability and various aspects of their human rights were not respected. For example, some people were subjected to neglectful practices and degrading treatment, were being deprived of their liberty unlawfully, were not supported to make decisions such as their choice of clothing or decisions relating to their health and welfare and were not adequately supported to maintain sufficient hydration or nutrition.

**This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Checks had been undertaken on the environment to ensure it was safe and people had individualised plans to

inform staff of how to support them to evacuate the home in the event of an emergency. Accidents and incidents had been recorded in accordance with the provider's policy. However, these had not been analysed or used to inform changes in practice in relation to people's care. This is an area of practice that needs to improve to enable the provider to be able to identify any trends and aid prevention in the future.

Medicine Administration Records (MAR) charts showed that people received their medicines on time. Observations showed that people were supported to take their medicines according to their preferences. For example, one person was supported to have their insulin administered in their preferred way. People were supported to take their medicine by trained members of staff who explained their actions and informed people of what the medicine was for. People's privacy when taking their medicines was respected and there were safe systems in place for the storage, administration and disposal of medicines.

# Is the service effective?

## Our findings

People were cared for by staff with little experience, knowledge or skills to meet their needs. Relatives told us that they felt that staff didn't understand dementia and how to care for people living with it. Observations confirmed that staff lacked the skills to communicate and interact with people living with dementia and failed to recognise their needs. One member of staff told us "The staff don't really know anything about dementia care."

Skills for Care state that it is important for staff to have the skills needed to carry out their roles, that those who work in health and social care need to make sure they are skilled, confident and competent to deliver high-quality care and that employers have a responsibility to ensure this. (Skills for care are an employer-led workforce development body for adult social care in England. They work with organisations across England to ensure that people have the right skills and values to deliver high quality care.) The provider had recognised this and had a policy that stated that they recognised the contribution that training and development made to the overall efficiency and effectiveness of the home. They had recognised that the induction process and the training of staff was not sufficient and following our inspection had devised a plan of how this would be improved with immediate effect.

Staff had undertaken inductions but had not received support to understand their role and responsibilities through an effective, formal induction process, learning and development or supervision. One member of staff, who had been employed by the new provider, told us "I had two induction days where I shadowed someone, then they put me on to work on my own. I've not been trained, I've honestly had no training. They threw me in at the deep end. They asked me to do things I didn't feel trained to do."

Staff confirmed and records showed that most staff had received training in moving and positioning, however, observations raised concerns about its effectiveness. One new member of staff, who had not received training in relation to moving and positioning, was working with another member of staff assisting a person to move from an armchair to a wheelchair. The new member of staff attempted to lift the person underneath their arms (this is not best practice as it places the person at potential risk of injury). Fortunately the other member of staff intervened and the new member of staff was advised not to do this.

Good quality training can help improve the lives of people living with dementia. Training should help staff understand what a difference they can make to people's quality of life by providing good quality person centred care. The majority of staff had not received essential training such as safeguarding adults at risk, equality and diversity, dignity, dementia, mental capacity or continence, although a workshop for this was booked. There was no training available for staff to enable them to meet people's specific needs such as diabetes care, wound care or nutrition and hydration. Staff were observed not engaging with people and were often standing around watching people. When people were calling out for assistance staff did not respond, instead they waited for a nurse to assist the person with their needs. The absence of training meant staff did not consistently have the knowledge and skills to provide good care which promoted positive outcomes for people.

The Social Care Institute for Excellence (SCIE) states that good supervision, be this in the form of observations of staff's practice or formal meetings, should result in positive outcomes for people who use services as well as the staff. (SCIE aims to improve the lives of people who use care services by sharing knowledge about what works well.) Feedback from staff was varied. Some staff had received supervision, however most told us that they hadn't, and the lack of records related to supervision confirmed this. Observations of poor care delivery demonstrated that staff had not been supervised undertaking their role, and that they had not been provided with guidance or feedback regarding their practice.

Registered nurses were registered with the Nursing and Midwifery Council (NMC). Where registration with a professional body is a requirement of the role, providers must make sure that staff are able to meet the requirements of the relevant professional regulator throughout their employment. This should include requirements for continuing professional development. Records showed that registered nurses had undertaken courses such as infection control and moving and positioning. However they had not been supported to undertake courses that related to the poor practices we observed and the care people received. For example, there were no training courses that related to supporting people with their continence, wound care or nutrition and hydration.

## Is the service effective?

There was a lack of appropriate support, training and supervision to enable staff to carry out their role to ensure that people were safe and well cared for.

### **This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 home was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. This related to a person who was unable to leave the home on their own due to risks to their safety and well-being. The provider fully understood the requirements of this legislation and had acted in accordance with it, therefore ensuring that this person was not deprived of their liberty unlawfully.

Observations identified that some people had bed rails in place. Under the Mental Capacity Act (MCA) 2005 Code of Practice, where people's movement is restricted, this could be seen as restraint. Mental capacity assessments should be decision specific and assess a person's ability to understand the information related to the decision being made. The person should be able to retain and weigh up the information and communicate their decision. Records should show how the decision of capacity was reached. Records did not clearly show that this had taken place, instead the person had been assessed as not having capacity purely because they were living with dementia.

Bed rails are implemented for people's safety but do restrict movement. Bed rails risk assessments were in place which considered the risk and how to eliminate the risk. However, despite the form prompting staff to consider the least restrictive options such as the use of low profile beds

or crash mats, these had not been considered. The bed rail risk assessment identified that the person, their next of kin or the GP were consulted and had consented to the use of bed rails. However, this was not the case and therefore it was not evident how this was decided in the person's best interest.

For people who had been assessed as lacking the capacity to consent to the use of bed rails the registered nurse or manager had undertaken a mental capacity assessment without the consultation or involvement of other professionals or the person's power of attorney. One relative told us "I'm power of attorney for my relative, but I've not been asked about bedrails." Records confirmed that despite the person having a power of attorney who could legally make decisions on their behalf, they weren't consulted or involved and bed rails had been implemented.

Some people were supported to have their medication given covertly. People who may not be able to make decisions about their treatment and care may need to be given their medicines without them knowing, for example hidden in their food or drink. The National Institute for Health and Care Excellence (NICE) guidance for medicines states that a best interest meeting should take place involving healthcare professionals (including the prescriber and pharmacist) and people's relatives or representatives to discuss and agree if this is the correct option. The person's GP should review their medicines as well as the pharmacist who should then advise the provider of how to administer covert medicines safely. If agreed, a management plan should be made which should contain information on these reviews, the decision taken at the best interest meeting and a date to review the need for continued covert administration of medicines.

There were five people who were assisted to have their medicines covertly. Best interest decisions had taken place between the provider and the person's representatives and there were signed forms to confirm this. However, a GP had not always been involved with these decisions and there was no involvement from a pharmacist or any documented guidance on how the medicine should be covertly administered in a safe way to avoid altering the structure of the medicines. One person's covert medicine plan had been reviewed once. There was a lack of involvement and

## Is the service effective?

guidance from healthcare professionals to ensure that the medicines were being administered in an appropriate way and a lack of reviews to ensure the continued need for covert administration of medicines.

Care and treatment of people must only be provided with the consent of the relevant person. Decisions for some people had been made by someone who was legally unable to make those decisions and best interest decisions had not always involved the relevant people. As a result people's movement was restricted and they were provided with medicines without their consent.

### **This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People appeared to have choice over the food they ate. The chef confirmed this, they told us "What they want I will cook if I can." The chef confirmed that people with diabetes were encouraged to have a healthy diet and for vegetarians there were options available to meet their needs. Records contained information about people's dietary preferences and observations confirmed that people were given their chosen meal.

The National Institute for Health and Care Excellence (NICE) guidance for nutrition states that healthcare professionals should ensure that care provides food and fluid of adequate quantity and quality and in an environment that is conducive to eating. People's dining experience was poor. The home was being refurbished and on the first day of our inspection there was no flooring in the dining room and people had to eat their meals sitting in the armchairs that they had been sitting in all day. This didn't help people to orientate and know that it was lunch time. People also struggled to eat independently when sitting in their armchairs as they were in a reclined position, therefore not aiding digestion or independent eating. As a result, people were observed to be spilling food down themselves which did not promote their ability to eat independently or maintain their dignity. On the second day of our inspection the dining room flooring had been laid and there were two small tables that five people could sit at to eat their meal. The majority of people still had to eat their meals sitting in armchairs using lap tables. The environment was uninviting and wasn't a pleasant or sociable experience for people to eat their meal. Following our feedback, the provider had ordered more tables and chairs to enable more people to sit at a table in the dining room to eat their meals. The

provider had recognised the lack of space in the dining room and had plans to extend the dining area to make the environment big enough to accommodate everyone during meal times.

There was a trolley next to the tables where people were eating, this was used to store used cutlery and plates and there was a container that staff used to empty uneaten food. This was done whilst people were still eating their meals, this did not create a pleasant environment for people to eat. The environment was not conducive to a social and relaxed meal time experience. There was minimal engagement between staff and people, the television remained on and there was loud music coming from a radio in the kitchen, which was not conducive to a relaxing environment.

People were not encouraged to eat and drink adequately. Staff knew which people required a soft diet and observations showed that they assisted people to eat their meals. However, staff stood over the person and assisted them with eating, rather than sitting discreetly beside the person. Three people were observed having three different members of staff assisting them to eat their meal simultaneously, each time a member of staff walked past the person they would assist them with another spoonful of food. This did not create a discreet or pleasant experience for the person and did not show respect for the person's dignity.

There was little interaction or communication with people when they ate their meals. Staff who offered support did not explain their actions, advise the person of what they were eating, ask if they were ready for some more food or if they were enjoying their meal. During the morning a person was given their breakfast. The person was clearly pleased that they had a cooked breakfast, however there was no interaction from the member of staff and the plate was placed in front of them with no talking or encouragement. It was clear that the person wanted accompaniments to go with their breakfast yet there were no condiments on the table for the person to use. The person continued to look around expectantly, no staff recognised this nor asked the person to determine what they wanted. The person looked disappointed and started to eat their breakfast without having this seasoned according to their wishes.

There was mixed feedback about the quality of the food. One person said that they enjoyed the food, they told us "I get a lovely bit of grub." Another person was overheard

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saying to a member of staff that the cake they had eaten was very good. However, observations of other people eating their meal indicated that people disliked the food provided. One person said that their fish was cold but they would eat what they could and another person asked for cider vinegar to put on their fish to disguise the taste. Staff told us that the food was not appetising. One member of staff told us “The food is awful, it’s not fair that they get mashed potato every day, twice a day sometimes. People don’t eat it and the staff don’t try to help them eat.”

People sometimes refused their food. One member of staff demonstrated good practice, when a person refused their meal, the member of staff offered them their pudding, when this was refused they were offered a cup of tea, however the person was still left having nothing to eat. Another person was offered a sandwich when they didn’t like their meal. However, two people who refused their meals had these taken away and were offered nothing else to eat. One member of staff told us “They refuse it and that’s it. We don’t have enough staff to get the food down people, it’s so basic.” Therefore people were at risk of not

having sufficient to eat as they were not encouraged to have suitable alternatives if they refused the food offered to them. For people who were malnourished there were no referrals made to dieticians or speech and language therapists.

People were not supported sufficiently by staff to eat and drink sufficient amounts to ensure their health and well-being was maintained. People were not provided with a suitable environment that was conducive to a positive dining experience.

**This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People were not consistently supported to access healthcare services or to maintain good health. There was a lack of consistency in regard to referrals that were made to external professionals. People had access to a GP and some referrals had been made to a psychiatric geriatrician and a tissue viability nurse (TVN).

# Is the service caring?

## Our findings

People's privacy and dignity was not maintained and their differences and individual needs were not respected. When talking about people staff often referred to people by their room numbers instead of using the person's name. One relative told us "Staff do their best but they do not know my relative and I worry each time I leave that they are not being looked after properly, I feel so upset when I leave here." A member of staff confirmed this, they told us "I haven't got a clue about anyone here and what they like. We get no time to sit with them and get to know them." Staff told us that they knew that the care needed to improve. One member of staff told us "I wouldn't put my relative here."

People were supported with little or no interaction from staff. When some staff were supporting people with their care needs there were no explanations or communication with the person to reassure them of what was about to happen. People were supported by some staff for whom English was their second language. They often had very strong accents which people found difficult to understand. One member of staff told us "There are issues with languages and communication." Observations confirmed this. When asking a person if they would like a drink the staff member continually repeated the word "Tea", the person could not understand as the staff member had a strong accent, instead of adapting the communication the staff member walked away, the person was left appearing confused as to what they were being asked and without a drink.

Although there were some positive interactions between staff and people, these were minimal. Staff appeared not to notice people's basic needs. A relative confirmed this, they told us "They don't know my relative. My relative's best time is at lunchtime. That's when you get the most out of them. I came in the other day and at 12:30pm they were still in their room, half slipping out of the chair and with all the curtains closed." Staff were often standing around, watching people, or appeared task orientated, there was no apparent stimulation or individual interactions with people. Observations found that some people looked unkempt, dishevelled and uncared for. Some people

appeared to be wearing un-ironed, dirty clothing and were not supported to clean themselves if food or drink was spilt, often having to wipe their hands and mouths on their clothing.

People wore aprons before they ate their meals, some of which appeared to be worn and dirty and people were often wearing them for long periods of time before and after their meals, which did not promote their dignity. Three people's nails were dirty and long and they had poor oral hygiene. One member of staff told us "We don't get time to brush people's teeth and take care of their oral care." Most females were seen to be wearing socks, with no stockings, tights or slippers and three people said that they were feeling the cold. One relative told us "I visited recently and the home was freezing. My relative was wearing a thin summer skirt and blouse with a thin cardigan. I know that my relative really feels the cold. I told staff that it was not an appropriate outfit and was told that it was what the night staff had chosen for her."

One person was being visited by their relative, the relative was concerned that their loved one wasn't their usual self and was unwell. The person appeared to be in discomfort with their throat and was coughing. The person was in the main communal lounge, however staff did not appear to notice the person's discomfort and the relative had to ask staff to get their loved one a drink and to call the nurse. The person's GP was called and visited the person later that morning. The relative told us "If I hadn't come today I don't feel confident that they would have called the GP." After the GP had visited the person was brought back to the communal lounge in a wheelchair. Observations of the person showed that they were in discomfort and their head was slumped backwards in the wheelchair. The person was becoming increasingly uncomfortable and reaching out for staff as they walked past, no members of staff stopped to ask if the person was okay or if they could assist and the person was left in this position for over an hour. An inspector had to intervene and asked staff to assist the person, who was then assisted to lie down.

Staff told us that most of the people were happy, but not all. One person was happy with the care, they told us "It's all good, the staff are nice, and they're good to me here." People should take time to listen to people's feelings and show patience and understanding when supporting people who are experiencing signs of distress or anxiety. Observations showed that one person was visibly

## Is the service caring?

distressed, they were crying and saying that they felt very down and depressed. This person made repeated requests to speak to their relative over the phone, however two members of staff did not respond to the person's requests. Another member of staff reassured the person and informed them that their relative would be visiting later that day. The member of staff asked another staff member if they could phone the person's relative. The member of staff said yes, but nobody got the phone. The person remained distressed for forty-five minutes. An inspector had to intervene and asked a member of staff to enable the person to speak to their relative. The member of staff did this and the person spoke with their relative and appeared reassured and their anxiety greatly reduced.

Observations of another person showed that they were distressed and trying to open the front door. Several members of staff walked past the person when they were doing this but no one stopped to talk or ask what the person wanted. Care plan records for the person's cognitive and behavioural needs identified that this person might stand by the front door and attempt to leave, it advised staff to treat the person with dignity and respect and to offer distraction techniques by offering to lead the person into the lounge or to sit in the reception area. Care staff did not support the person. After a period of time and increased anxiety a member of staff who was not part of the care team asked the person to sit in the lounge.

One person was being supported from their room into the lounge area using a wheelchair, the member of staff knocked the person's hand on the frame of the door and the person shouted and said it hurt. The member of staff did not respond, instead they left the person in their wheelchair in the middle of the room and asked another member of staff to further assist the person. The person became agitated and started to swear, asking for the nurse and stating that they could tell when people didn't care. There was no attempt made by the member of staff to reassure or comfort the person, they called the nurse who appeared to know the person well, the nurse supported the person to calm down and sit in their chair.

There was a strong offensive odour within the home. Observations showed that people were not supported to access the toilet facilities regularly. When people tried to stand up staff immediately told them to sit back down without asking them what they wanted and how they could help. One person was supported to walk to the table to

have lunch, there was a strong odour and the person's trousers were visibly very soiled, staff did not notice this and the person was asked to sit at the table with other people to have their lunch. Staff were asked how people were supported to use the toilet facilities, one member of staff told us "The pad changing is a disgrace. The pads are being used instead of using the toilet. People aren't taken to the toilet. We're told to wait until the pads are full." This did not support people's dignity or promote their independence with their continence needs.

Relatives confirmed this, one relative told us "My relative never gets supported to use the toilet, the staff are told that they have to use their pads. I came in the other day and my relative had a blanket over them, I pulled it back and their legs were soaking wet." Another relative also told us that they had recently visited their relative to find them sitting in a wet chair with wet and soiled clothing. When the relative had asked staff why it had happened they were told that staff were too busy. The relative then had to assist another member of staff to support their relative with their personal hygiene needs. Records confirmed that people were not encouraged to access the toilet regularly and that there was an over reliance on the use of incontinence pads. People had elimination care plans, one person's care plan identified that the person had no control over their bladder or bowel. The action that staff had been advised to take was to ensure that the person's incontinence pad was changed when required. There were no plans to regularly remind or prompt the person to use the bathroom. Due to people not being supported with their continence needs the chairs had protective covers on them, these contributed to the offensive odour and an environment that was undignified.

People's independence was not promoted. One relative felt that their loved one could do more and would benefit from this, explaining that the person had lived on their own in their own home until recently. People were not encouraged or enabled to be independent. Observations showed that one person was sitting at a small table facing a blank wall, the person had sat there for a period of time and attempted to stand, staff noticed and immediately asked the person to sit down, this happened several times and staff did not ask the person what they wanted or if they could assist. Another person wanted to spend some time in their room. The person asked a member of staff if they could go to their room and were told that they weren't allowed to and had to stay where they were until it was

## Is the service caring?

time for bed. The person was sitting on a dining chair and was obviously uncomfortable. This was unnecessarily restrictive and did not enable the person to choose where they spent their time. Another member of staff then assisted them to move to a more comfortable armchair and some positive interaction took place, the person was encouraged to talk about what they used to enjoy doing when they were younger.

Records showed that a resident's meeting had taken place, during which people were asked for their opinions on their choices of food and activities that could be offered. However there was no involvement of people in decisions that affected their care on a daily basis.

People were not respected or treated in a dignified way.

**This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

# Is the service responsive?

## Our findings

People did not receive personalised care that was responsive to their needs. New care plans were in place, however most pages were incomplete. The provider was in the process of implementing a new system for the care plans and staff were positive about this. One staff member told us “The new paperwork system is good, it will be a lot more professional, improvements are happening.”

There was a lack of stimulation and people were at risk of social isolation. One person was observed spending time in their room all day with very loud pop and rock music playing, there was no evidence to suggest the person had chosen to listen to this type of music. The person’s care plan stated that the person disliked noisy environments and enjoyed listening to light, classical guitar music. The person was on their own in their room all day, staff took the person drinks and meals however there was no other interaction with the person. Care records showed that although the person liked their own company, they did not like complete solitude.

Another person spent all day on their own in their room, the person was constantly calling out for help. Staff were observed to walk past this person’s room without stopping to ask if they were okay or if they could assist them with anything. This person’s communication care plan stated that they liked to have one to one time with staff, that they enjoyed being read to and would appreciate it if staff spent time communicating on a daily basis. The care plan also stated that if the person was alone in their room that staff should check on the person regularly. Observations showed that apart from providing the person with their lunch and drinks there was no interaction between staff and the person. There was no record to indicate that staff spent time with the person in accordance with their assessed needs. When staff were asked about the person’s needs they told us that the person always called out and that they didn’t really need any assistance, the care plan did not detail the person’s anxiety and there were no plans of how to support the person to reduce their anxiety or manage the behaviour.

Observations of another person spending time in their room showed that the person had been vocal and distressed the entire day. The person kept scratching their leg and trying to lift themselves out of their chair. This person’s room was by the entrance to the home and beside

the main office, however no members of staff checked on the person and asked about their welfare. Interaction with the person only occurred when staff took the person their lunch and drink. There was no acknowledgment of the person and no interaction or conversation and the person appeared to remain anxious. Daily records showed that the person had spent the last nine days in their room. Care records for the person’s cognitive and behavioural needs identified that the person needed to be orientated to time, people and place and that they needed reassurance when they became anxious, as well as needing support to participate in activities. Despite this the person was not reassured and when a musical entertainer was playing the organ and singing songs in the lounge the person remained in their room and we observed that no attempts appeared to have been made to assist them to join in the activity. This person had some visitors in the afternoon and this appeared to really cheer the person up, they relaxed and became less anxious when they had visitors, therefore showing that the person responded well to interaction with others.

One person, who was in their room all day, was often calling out in apparent anxiety. Two members of staff were observed walking past the person’s room without going in to see if the person was distressed and if they could be of any assistance. Observations of the person showed their appearance to be very unkempt, their hair appeared unclean and they were slumped in their chair with their feet on a footstool, so they were unable to move independently. The person wore clothing that appeared un-ironed, their nails were very long and unclean and they felt cold. The person had no drink and appeared to be very distressed and showed signs of discomfort in their mouth, continually coughing and opening their mouth as if expecting a drink. The person’s room was very bare, with no personal effects or decoration to aid orientation. There was no stimulation for the person. An inspector had to intervene and asked the provider to immediately address the person’s needs. A nurse checked the person’s mouth and staff were observed sitting with the person in their room, trimming the person’s nails and offering them a drink.

When staff were asked about how they reduced social isolation for people who spent the day in their rooms they explained that they checked on people when they took them drinks or food. One member of staff told us “We never get time to sit in people’s rooms who stay in there on their own. We could get to know them if we had the time. They

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are just ignored.” Another member of staff told us “We talk to people in their rooms when we give them food or fluids or do observations.” When we spoke to someone who had spent the day in their room, they told us “It’s a bit boring, I don’t know what I’m doing.” Relatives also recognised that people were not having access to interaction or stimulation. One relative told us “Nobody looks in to see them or sit with them. There are no activities for them in their room, they do some activities, but they’re not relevant for my relative.”

The Alzheimer’s Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for people living with dementia and that taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. People had very little stimulation and the provision of activities was minimal. People were sitting in their armchairs for most of the day, there was a television on in the main lounge. However people did not appear to be watching this and it was situated in a position that meant that only a small number of people could see it. Staff told us that people did not get enough activities and that there was nothing for people to do. One member of staff told us “There aren’t very good activities at the moment, they sit in those chairs all day until they go to bed.” Another member of staff told us “I feel really sorry for the residents here, they must be so bored.”

People were not supported to go out of the home unless they were supported by their relatives. One relative told us that their relative would like to go out and would like to think that they were supported to do so. However, one person told us “I don’t get out.” Staff recognised that people would benefit from spending time outside of the home. One member of staff told us “I think some fresh air would be good for the residents, to get them to go outside.”

There was an activities board displayed in the dining area informing people of activities offered, however staff said that these didn’t take place. When we asked the provider at the start of the inspection if there were any activities planned for that day we were told that there weren’t and that staff would be spending time with people. We were able to see a member of staff assisting people to have their nails painted and playing a board game with a person who appeared to really enjoy this. However a relative was overheard saying to staff “You don’t usually do that, it is only happening as CQC are here.” During the afternoon the

provider played the organ and sang some songs, people really enjoyed this, one person was singing along with the music and another was seen dancing with a member of staff, this lifted the atmosphere in the home and people were seen to be having fun and smiling.

Most people’s care plans did not yet have information about their interests, hobbies, earlier life or things that were important to them. Care plans were based around people’s needs. However, observations of people being supported raised concerns regarding their guidance, effectiveness and implementation. Six members of staff we spoke to couldn’t provide any examples of how they supported people in a person-centred way. One member of staff could provide very basic information in relation to people’s preferences informing us of how a person liked to have their hair styled or the necklace that a person liked to wear.

Care plans showed that some relatives had been involved in its development. When relatives had been involved in the development of the care plan it contained more information detailing the person’s preferences, however despite this information people didn’t appear to be supported according to their care plans.

Reviews of people’s care plans had taken place. One review showed that the person’s family had been involved and changes made to the care plan as a result. For example, an implementation of a DNACPR (Do not attempt Cardio-pulmonary resuscitation) form for the person. However one relative told us “They never inform me about my relative and I’ve not been involved in any care reviews.” Most care plans had been reviewed by the manager or nursing staff, however reviews failed to recognise when action needed to be taken to address concerns over a person’s health and well-being or when a referral to an external professional was required. This is an area of practice in need of improvement.

People appeared to be given minimal choice. Staff told us that they did their best for people but they didn’t have enough choice. Observations showed that people were given a choice of what squash they would like at lunchtime, however, staff were also observed handing out cups of tea and bowls of crisps to people in the afternoon with no interaction or choice provided to the person. Another person was supported by a male member of staff, the person was anxious and distressed and when the staff member was asked if the person minded having a male

## Is the service responsive?

carer they told us that the person used to mind, but not anymore. This posed a question as to whether the person's preferences were now not being respected due to the deterioration of their condition as nothing had been recorded in the person's care plan to indicate that their preference had changed. This is an area in need of improvement.

People did not receive the care and treatment to meet their assessed needs or reflect their preferences or wishes.

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

The provider had a complaints policy, there were ongoing complaints that were being investigated that had been made under the previous provider and records showed that the manager had met with people's relatives to resolve any concerns or complaints they had. One relative told us about a situation that had occurred regarding the care of their relative. They had reported this to the provider who had investigated the incident and care had changed as a result, records confirmed this.

# Is the service well-led?

## Our findings

There was mixed feedback regarding the new providers. Some staff felt that the providers were not approachable and didn't listen, whilst others were happy with the change, they felt it was positive and they felt listened to and respected.

The providers had taken ownership of the home in September 2015, they explained to us that they had been left in a difficult predicament by the previous provider and recognised that the home, and the care provided, needed significant improvement. In October 2015 the registered manager and deputy manager left the home and another interim manager was recruited. A new permanent manager needed to be recruited to drive improvements and change to improve the care people received. The providers had employed a manager who was going to apply to be the registered manager of the home. During the two day inspection both managers were working to enable an effective handover of information and at the end of the second day of the inspection the interim manager left employment. Following the inspection the new manager also left employment.

The providers were in the process of undertaking extensive improvements to both the environment and the care which people received. The providers showed a commitment and willingness to improve. The concerns from the inspection mainly related to observations of staff practice and their interactions with people, staff were not supervised providing care and support to people and had therefore not been provided with appropriate supervision, support or feedback that could have addressed the shortfalls in regards to the quality of care people received. There was a lack of direct supervision and leadership. The provider had not assured that both registered nurses and care staff had received training to ensure they had the relevant skills to meet people's specific needs, this had a direct impact on the care people received. The provider had recognised that staff needed more supervision and was in the process of recruiting a deputy manager who would be responsible for observing and monitoring staff's practice to ensure people's care needs were met appropriately.

There were not robust quality assurance systems and processes. A range of quality assurance audits should take place to ensure that the systems and processes used are effective, this also helps to identify areas of practice that

need to improve and drives change. The provider had quality assurance systems in place for some aspects of the home, however these were focused on the general management of the home. Despite some audits of the medication systems, infection control and pressure area care there was a lack of clinical audits, supervision and oversight that monitored the nursing care that people received. For example, an audit of the pressure area care had taken place once and had not recognised that people were not being supported according to the recommendations of the TVN or the tissue viability care plan. The provider did not monitor or analyse people's weights or food and fluid charts. People had been losing significant amounts of weight and had been refusing their food, this was not recognised by the provider and people didn't get the support from external professionals as a result.

The provider had taken measures to ensure that new staff employed were safe to work in the health and social care sector. Disclosure and Barring Service (DBS) checks undertaken, and references obtained. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions. It also helps prevent unsuitable people from working with people who require support and care. However, staff files of existing staff that had been employed by the previous provider did not have suitable checks in place. When taking over ownership of the home the provider had not assured themselves that the people they were employing were safe to work within the home and did not maintain adequate records.

There was a lack of strong leadership, management, and oversight to ensure that staff provided care that met people's needs as were outlined in the philosophy of care and their care plans. The provider had failed to notice that people's care needs were not being addressed and as a result people were at risk of receiving inadequate care that didn't meet their needs.

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

The provider had a statement of purpose and philosophy of care, this stated that the provider would work with people and their relatives to ensure people's comfort,

## Is the service well-led?

dignity, safety, security, independence, choice and privacy and to provide a service that reflects the lifestyle and wishes of older people. This philosophy of care was not delivered in practice.

The home had an institutional atmosphere, it did not ensure people's comfort and people were not supported to live the lifestyle that they would choose. One member of staff told us "The home used to have a homely atmosphere, but not too much now." There was a low morale amongst the staff, another member of staff confirmed this and told us "The culture and mood is so low." There was mixed feedback from relatives, some could see the improvements the provider was making and were happy with the care provided, others were not happy and one relative told us "I have no faith left in this place."

The providers recognised that the home needed significant improvements when they first took ownership, they were committed to ensuring that the experiences people had were positive and that they received good quality care. They had produced an action plan identifying areas of concern that were in need of improvement, the action required and the timescale that it was to be achieved by. However, the provider had appeared to concentrate on the décor and environment. The home had been part-refurbished with new paintwork, lighting and flooring that created a more pleasant environment for people to live. People's needs in relation to their health and welfare had not been sufficiently considered within the action plan.

Measures had been taken in the short time that they had owned the home to improve partnership working and involve people and their relatives in decisions that affected their care. Relative's and resident's meetings had started to take place and there were plans for these to be held on a frequent basis as well as regular reviews of people's care plans with the involvement of their relatives. Records were in the process of being improved and new records that were in the process of being implemented demonstrated that there would be more robust and effective systems used to record and monitor people's care to enable shortfalls to be recognised and actions taken as a result.

The providers were receptive to the feedback provided after the inspection. They explained that it had been very difficult for them since taking over, that they hadn't realised the extent of the issues and were frustrated that their plans to improve the home could not be implemented straight away. They recognised that it would take time to get the home and quality of care to the standard people had a right to expect. They showed commitment and enthusiasm to address the areas of concern and following the first day of our inspection had already put measures in place to monitor people at risk of malnutrition. Following the second day of the inspection the provider had produced a comprehensive action plan that identified all of the points raised within the feedback as well as others that they were already working towards.

This section is primarily information for the provider

## Action we have told the provider to take

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

| Regulated activity                                             | Regulation                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care                                                                                                                                                                                                                                                                                                                                    |
| Treatment of disease, disorder or injury                       | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014. Person-centred care.<br><b>Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.</b><br><b>The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.</b> |

| Regulated activity                                             | Regulation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Treatment of disease, disorder or injury                       | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014. Need for consent.<br><b>Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.</b><br><b>The registered person had not ensured that suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.</b> |

| Regulated activity                                             | Regulation                                                                                            |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment |
| Treatment of disease, disorder or injury                       |                                                                                                       |

This section is primarily information for the provider

## Action we have told the provider to take

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

**Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.**

**The registered person had not ensured that service users were protected from abuse and improper treatment.**

**Systems and processes were not established or operated effectively to prevent abuse of service users, investigate, immediately on becoming aware of, any allegation or evidence of such abuse.**

### Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good governance.

**Regulation 17 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.**

**The registered person had not ensured that systems and processes were established and operated effectively to:**

**Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).**

This section is primarily information for the provider

## Action we have told the provider to take

**Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.**

**Maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity.**

This section is primarily information for the provider

## Enforcement actions

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

| Regulated activity                                                                                         | Regulation                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014. Dignity and respect.<br><br><b>Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.</b><br><br><b>The registered person had not ensured that service users were treated with dignity and respect.</b> |

### The enforcement action we took:

A warning notice was served under section 29 of the Health and Social Care Act 2008. The provider is required to be compliant with Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations by 11 March 2016.

| Regulated activity                                                                                         | Regulation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.<br><br><b>Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Safe care and treatment.</b><br><br><b>The registered person had not ensured that suitable arrangements were in place for ensuring that care and treatment was provided in a safe way and had not effectively assessed or mitigated the risks to service users.</b> |

This section is primarily information for the provider

## Enforcement actions

### The enforcement action we took:

A warning notice was served under section 29 of the Health and Social Care Act 2008. The provider is required to be compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations by 11 March 2016.

### Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

### Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.**

**Regulation 14 (1) (2) (a) (b) (4) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.**

**The registered person had not ensured that the nutritional and hydration needs of service users was met, they did not ensure that there was adequate support for a service user to eat or drink.**

### The enforcement action we took:

A warning notice was served under section 29 of the Health and Social Care Act 2008. The provider is required to be compliant with Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations by 11 March 2016.

### Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing.**

**Regulation 18 (1) (2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.**

## Enforcement actions

**The registered person had not ensured that there were:**

**Sufficient numbers of suitably qualified, competent, skilled and experienced people**

**That staff had received appropriate support, training professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.**

**That where staff are health care professionals registered with a health care or social care regulator, they be enabled to provide evidence to the regulator demonstrating that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.**

### **The enforcement action we took:**

A warning notice was served under section 29 of the Health and Social Care Act 2008. The provider is required to be compliant with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 by 11 March 2016.