Aaroncare Limited

Aaron Lodge Care Home

Inspection report

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Date of inspection visit:
31 May 2016
01 June 2016
02 June 2016
10 June 2016

Date of publication:
27 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced comprehensive inspection on 31 May, 1, 2 and 10 June 2016. The service was previously inspected on 19 and 23 November 2015. The service was rated inadequate and placed in special measures. They were found to be in breach of Regulations relating to person centred care, dignity and respect, medicines, Hydration and nutrition, governance and staffing. We received an action plan from the provider detailing what improvements they were going to make in the care home. We received information of concern from members of the public prior to our inspection and from Statutory Notifications received from the care home.
At our most recent inspection we found the service remained in breach of the same regulations as were evident on our last inspection in November 2015, apart from medicines where improvements had been made. The service was also found to be in breach of regulations in relation to the need for consent and safeguarding service users at our most recent inspection.

Aaron Lodge is a dementia care residential home which is located close to Liverpool city centre. The home is registered to accommodate 48 people. At the time our inspection, there were 48 people living at the home.

There was a registered manager in post at the time of our inspection. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The service was not always safe and people were at risk of harm to their health and well-being due to poor systems of communication, under reporting of incidents and not having sufficient numbers of staff. Actions stated as being required in people's care plans were not always followed which put them at further risk of harm.

There were deprivation of liberty authorisation applications seen in the records but we found that the best interest's process was not always being followed.
Staffing levels were a concern as we found people's care needs were not being met. The service was using a dependency matrix which was designed for determining nursing staff provision and not suited to the care needs of people with dementia in a residential care home setting.

The registered manager had completed some audits such as infection control and incidents. Other audits had been delegated to carers to complete. Despite these audits being completed which demonstrated a commitment and drive to improve, we were concerned about the effectiveness of the monitoring of systems in place which were failing such as the systems of communication, system of reporting incidents to the registered manager and systems of documenting pertinent information related to the health and well-being of people to keep them safe.

We observed people at various times of the day and found the mornings and lunch times were more

pressured than other times of the day for staff to meet people's care needs. This had not been factored into the staffing levels within the care home and the impact of this for people was that they were not being supported to go to the toilet in a timely manner. People were not receiving drinks throughout the day and they were not being supported to eat and drink when they were provided with sustenance on a table in front of them.

A recommendation was made from the last inspection in November 2015 regarding improvements needed to the design and decoration within the care home to meet the needs of people with dementia. We found dementia friendly knitted hand muffs had been made but were not yet used and the bathroom doors had signage which was a different colour to stand out for people but no other improvements had been made. The registered manager told us that they had not sought the advice of someone with the skills in dementia adaptation/design other than their own in-house painter and decorator who decorates all care homes owned by New Century Care.

Safeguarding procedures were in place but they were not always being followed by staff. We found incidents were documented in the daily records which had not been reported to the Local Authority.

Staff recruitment included a DBS check (Disclosure Barring Service) to ensure staff were checked for previous convictions prior to working within the care home and staff received an induction.

Not all staff were up to date with training including safeguarding, hydration/nutrition and pressure care. However, a supervision structure was in place and the registered manager had completed supervision sessions specifically related to infection control and hydration.

We observed a medication round during our inspection and found that the breach in respect of the safe administration and recording of medications, identified at the last inspection, had been met.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Information regarding people's health needs was not being recorded in the records.

Staff were not reporting all incidents seen in the records.

People were observed unsupervised in the lounges and in their rooms with insufficient staffing levels to meet their needs.

Not all staff had up to date training in Safeguarding.

Is the service effective?

Inadequate

Consent was not always being sought and there was no evidence that best interests' processes were being followed.

People were not always given choices of what they would like to drink and were being restricted to drink at specific times of the day.

The system of recording fluids was failing resulting in inaccurate recordings leading to an inaccurate assessment of people's health needs.

Health care professionals were involved in people's care.

Applications had been made to the Local Authorities to deprive people of their liberty where needed in accordance with policy.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were unable to spend time with people to converse or engage with them.

The care being provided was task orientated.

People did not always have choices.

Relatives were encouraged to visit when they chose to.

Is the service responsive?

Inadequate

People were not receiving person centred care.

People were not being provided with sufficient activity to maintain their health and well-being.

Care needs were not always being recorded and people were not receiving care when they needed it.

Learning was not always taking place from complaints made.

Is the service well-led?

Inadequate

The service was not well led.

Quality Assurance Monitoring of systems were not identifying what needed to be improved.

The records were not robust at all staff levels.

Communication at all levels was not effective.

Aaron Lodge Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection of Aaron Lodge Care Home took place on 31 May, 1, 2, 3 and 10 June 2016. The inspection team consisted of one adult social care inspector and a specialist advisor who was a qualified nurse with skills in dementia care.

A Provider Information Return had not been requested prior to our inspection. We received concerns from members of the public prior to our inspection and these concerns were shared with the Local Authority Safeguarding Team. Healthwatch were also contacted as part of our information gathering.

We spoke to people who lived in the care home and relatives who were visiting at the time of our inspection. We spoke to staff who worked there including the chef, domestic staff, carers, senior carers, deputy manager, the registered manager and the area manager.

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

We viewed 12 care plans, other care records and policies. We also viewed six staff files and spoke to five healthcare professionals. We case tracked five people who lived at the care home.

The local authority and health authority were contacted to request their views as part of our inspection.

Inadequate

Is the service safe?

Our findings

Due to people's different levels of ability, some people were unable to verbally communicate their views to us. However, one person who we spoke to who was able to understand questions asked and was able to talk to us. They told us they did feel safe at the care home.

We looked into whether there were enough staff to meet the needs of people living in the care home. Staff members we spoke with told us the workload on the ground floor was 'harder' than the workload on the top floor but the staffing levels were the same on both floors. Staffing levels had increased by one carer on each floor since our last inspection and although staff told us this was an improvement, they still highlighted staffing issues. Two staff members we spoke with told us they were unable to meet the needs of one person in particular whose behaviour was challenging. The staff members both expressed concern that the person needed one to one care in a nursing care home.

We observed staff rushing from one task to the next and they were unable to spend time with people to encourage them to eat and drink. We observed people who needed support to eat and drink were not receiving encouragement from staff to ensure they were drinking and eating. One person we observed was sitting with their cold cheese sauce with pasta in front of them. We observed two people sitting opposite one another with their food on plates in front of them. We observed one person grabbing food with their hand off the other person's plate who was sitting with their head down not eating and unaware what was happening. According to fluid balance charts we found fluids were not given after 10pm and there was no evidence of any access to fluids in the home apart from set times of the day. We observed one person walking down a corridor with their cooked breakfast spilling off their plate onto the floor. We read in the person's care plan that they needed encouragement and support at meal times. Due to lack of staff supervision, people were not receiving adequate support or supervision to ensure people were eating and drinking.

We observed people with severe cognitive difficulties due to dementia were not receiving adequate support or supervision. People who were able to walk around the care home were observed wandering without purpose at times trying to abscond by trying the door and the keypad. On the third day of our inspection we observed the fire alarm had been set off by one person on the top floor who was unsupervised. Another person was sitting in their room wearing nightclothes with their breakfast down their top garment all day during one of the days of our inspection. We read in their care records that the night staff had not supported them to get dressed as they needed to have a shower. This did not happen and therefore, the person was left in their nightclothes all day.

We observed people's needs were not being met in a timely manner and there were not sufficient staffing levels to meet people's needs. For example, we observed one person who was distressed shouting for assistance for a period of 20 minutes before a staff member attended. The person was distressed due to them being incontinent of faeces with faeces visible on both legs. The person had no means of alerting staff other than repeatedly shouting out. One staff member we spoke with told us "We are short staffed a lot because staff will call in to say they are not coming in at short notice and they can't get staff to cover". We saw evidence of this written on a handover sheet dated 30 May 2016. It said "X not coming in tomorrow (sick)

shift covered." Also "X off sick no return date, X sick two weeks X off sick one week shift covered." There were four staff names on one handover sheet reported to be off work.

We asked to view the service's dependency matrix as we had been informed staffing levels had improved since our last inspection and a dependency tool was being used to calculate how many staff were needed to meet the needs of people. The dependency tool we were provided with was titled - 'Staffing Guidance for Nursing Homes June 2009 by the Regulation and Quality Improvement Authority'. The tool provides a score which then determined how many hours of care a person required each day. As the tool was designed for people who required nursing care, it was focused to nursing care tasks and was not meeting the needs of people with dementia. The registered manager informed us that they had been directed to use the tool to determine how many staff were needed but highlighted that it was not appropriate for a setting for people who were living with dementia. We provided feedback explaining our concerns that the tool was not capturing the time staff needed to engage with people with dementia for a long enough period to provide them with stimulation, comfort, encouragement or reassurance.

This is a breach of Regulation 18 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. There were not adequate staffing levels to meet the care needs of people with dementia.

We looked into how people would alert staff in the event they felt unwell or needed the staff urgently. There was a call bell system in place but no one within the care home had been assessed as able to operate a call bell. Therefore, the only means people had of alerting staff to them needing help was to locate an emergency call bell on a wall, raise their voice or to walk around the care home to find a staff member. There were no systems in place for checking people who did not have the capacity to monitor their own needs who were in their bedrooms. We spoke to one person who was able to tell us what they would do if they needed staff urgently. The person said they would press the emergency button on the wall at the side of the bed. This meant the person would have needed to get up from their chair and walk across to the bed and lean across to the wall to press the emergency call bell. The registered manager told us they would speak to the person about whether they would like the option of using a call bell.

There were emergency call bell panels on the walls in the communal areas and an emergency first aid bag located in between both floors on the stair case. We checked the contents of the emergency bag which contained items such as a resuscitation mask. We asked staff what they would do in an emergency and the staff we spoke with were aware to raise the alarm in the first instance.

We opened a bedroom door which was unlocked. We found a person lying on their side with their legs half on/off the bed at risk of falling off the bed. On closer inspection we observed the person's door had a fire guard fitted but it failed to wedge open. We requested the maintenance staff assessed this immediately and they found the fire guard battery was no longer working and needed to be replaced. This posed a fire risk and had not been identified by staff over the bank holiday weekend.

We spoke to the maintenance person who explained their role within the care home. They explained water checks were undertaken monthly, fire door inspections monthly, weekly checks of fire escapes and staircases, weekly fire alarm checks and a fire drill was completed a week before our inspection. They told us the fire service were due to visit the care home the following week and they had partially developed evacuation procedures for people in the care home. The annual legionella checks were being undertaken in the care home during our inspection on 2 June 2016 and we viewed the electrical certificate, gas safety certificate and documentation which were up to date.

We received a Statutory Notification of a RIDDOR (Reporting of Injuries, Diseases and Dangerous

Occurrances Regulations) prior to our inspection. On inspection we viewed the care plan, incident book and daily records to look into the circumstances in which a person fell and was hospitalised. The care plan stated that the person required the assistance of one staff member when walking however the person fell whilst walking without a staff member assisting. Therefore, the service failed to follow the care plan recommendations and this resulted in the person sustaining a serious injury.

This is a breach of Regulation 12 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider failed to ensure that care and treatment was provided in a safe way.

We viewed the care plan and daily records of a person and observed entries where the person had harmed or injured themselves. This was by banging themselves when walking around the care home, lashing out at objects resulting in an injury, pulling their hair in a distressed state and screaming and undressing in view of others in the garden. The incidents were not all being reported to the Local Authority. We also viewed the handover sheet dated 30 May 2016 which stated "Bruising how sustained?" but this had not been reported or followed up by the deputy manager. We requested the registered manager reported the bruising to safeguarding. On viewing the training matrix we found not all staff were up to date with their safeguarding training and two out of 6 staff files viewed did not have up to date safeguarding training certificates.

This is a breach of Regulation 13 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider failed to implement effective systems and processes to protect people from abuse.

Inadequate

Is the service effective?

Our findings

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 supported 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Our findings were that the registered manager had applied for a Deprivation of Liberty Authorisation for all the people at the care home.

We observed people's bedroom doors were being locked by staff when they left their rooms. The area manager told us they understood only the people who were unable to walk back to their rooms had their doors locked to prevent people who wander around the care home from entering other people's rooms. The registered manager confirmed they were in fact locking all bedroom doors when people left their rooms. We found this practice was on going in the absence of a best interests' process being followed. In the absence of a best interests decision being followed locking someone's door could be a deprivation of their liberty. Despite this being pointed out to the registered manager and area manager at the last inspection, we found the same practice was continuing when we returned to visit the care home on 10 June 2016. The registered manager informed us the service did address this by undertaking a risk assessment. We viewed the risk assessment in place which was a list of questions such as whether the person was able to hold a key to open their door. A decision was being made by a staff member answering the questions on the form whether the person's bedroom door should be locked when they are not in their bedroom. We explained to the registered manager this was not acceptable practice and other people should be consulted as part of a best interest decision.

This is a breach of regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that staff were working in accordance with the Mental Capacity Act 2005.

We looked at six staff files to check if they had received an induction and training prior to them starting to work at the care home. From the six files we looked at we found one person had started working at the care home having not received safeguarding training. We were assured by the registered manager that the carer would complete safeguarding training by an e-learning method within a week of this being highlighted. According to the certificates seen in another staff member's file their safeguarding certificate expired on 17 October 2015. We were informed by the registered manager the person had completed safeguarding since it had expired but we were unable to verify this as there was no certificate for us to view.

The training matrix showed 100% of staff were up to date with training for infection control, medication and dementia awareness. However, 67% of staff were up to date for nutrition and hydration, 38% had up to date

training regarding pressure care, 32% were up to date with training on falls awareness and no staff had received training in end of life care despite two people receiving end of life care at the time of our inspection. For those staff who had completed training in infection control and hydration we found the registered manager had also met with staff to undertake a one to one session and to check their understanding however, this was not the case with other aspects of training. The provider confirmed that their training schedule consisted of some aspects of training which were mandatory and other aspects were discretionary.

This is a breach of regulation 18 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure all staff had received up to date training.

Staff we spoke with were asked for their views regarding how well they were supported by their managers all staff we spoke with were supportive of the registered manager. We saw evidence the registered manager had completed supervision sessions with staff members specifically around infection control and hydration/fluids. Staff told us they received supervision and they would speak to the registered manager if they had any concerns. The registered manager told us they were usually supported by a community matron service but this had not been provided since January 2016. We were informed that the community matron would be available for advice or to visit people in the care home. In the absence of a community matron the registered manager told us they would contact the GP or district nurse for advice and support.

We had the opportunity to speak to a range of health care professionals and also viewed documentation where we could see healthcare professionals were being involved in people's care but not always in a timely manner. One health care professional we spoke with questioned the accuracy of the recordings in the care records to effectively monitor people's health as the records were not consistent with their findings. They told us they were concerned that according to the records of what one person was eating and drinking the person should be either maintaining or increasing their weight when according to the records they had lost weight. Another healthcare professional we spoke with told us they had seen an improvement in the care home since our last inspection and had noted a reduced number of people suffering with urine infections. Drinking enough fluids is important to prevent a urine infection developing. They told us they did have concerns in the past regarding hydration but this had improved.

We spoke to the chef who told us the menu was changed every four weeks and there was a choice of two meals at each meal time. The chef worked a 12 hour shift and they had an assistant for six hours each day. We observed meal times in the care home. Most people were observed eating in a dining area or in an area set back from the main lounge. We observed the dining tables did not have water jugs and drinks were being supplied individually from a trolley. Therefore, people were unable to help themselves to a drink when they wished. Staff were bringing salt and pepper to the tables and were observed asking people if they would like salt and pepper. People were being restricted from independently seasoning their food when they wished to. Not everyone ate at the same time when sitting around a table to eat. This led to one person sitting on their own eating as others around the table had finished their food not providing a pleasurable dining experience for the person. Some people were not being provided with assistance to eat when they needed it and were sitting with food in front of them.

We observed staffing in the communal areas. People were not always being supervised in the lounges. One person in the lounge reached out to us and asked us for a drink. They repeatedly banged their fist on the table in front of them. Another person asked for a drink. There were not enough staff supervising people in the lounge at this time and no access to water visible for people. We spoke to staff regarding the system in place for people to have a drink. Staff told us the drinks are brought round on a trolley at breakfast time, 11am, lunch time, 2pm, tea time and supper time and we observed that drinks were served at these times.

We looked into the system of recording what people had taken to drink. Staff were observed transferring information from a sheet of paper onto a fluid balance chart. We raised concern about this system as staff were then later seen retrospectively entering estimated amounts people had taken to drink or eat onto the fluid and food chart. We were told that carers recalled how much people had taken and there were no other methods being used to record how much people were eating or drinking. We observed people who were in their rooms who also did not have access to jugs or cups of water. The specialist nurse advisor viewed fluid balance charts and confirmed most of the fluid charts stated 200mls for each drink given and most daily intakes were recorded as 1400mls in 24 hours. We spoke to the registered manager and expressed concern that retrospective completion of charts was not an accurate method and the system in place was not effectively monitoring people's fluid or food intake. For people who are at risk of malnutrition or dehydration, inaccurate recordings of what people have eaten or drank daily can then place them at unnecessary risk of dehydration or malnutrition being detected early on. This can then lead to a delay in appropriate medical/health care advice being sought in a timely manner.

We checked to see if people who were prescribed supplements written on their Medication Administering Record (MARS) were receiving them. We found the supplement was being placed in front of people but people were not always receiving support to drink them. We observed one person had a supplement drink placed in front of them in the morning and by the afternoon they had two supplement drinks placed in front of them on the table. We were unable to check how much of the drinks the person had drunk as supplement drinks were not being recorded on the fluid balance chart. From picking the drink containers up we estimated the person had drank under half the full amount prescribed but we did not observe the person drinking the supplement.

During our inspection we found one person was admitted to hospital with dehydration. We viewed the person's fluid balance charts and we also spoke to healthcare professionals who confirmed the reason for the admission was due to the person being dehydrated from not drinking enough fluids. The person's confirmed diagnosis was dehydration resulting in an acute kidney injury. We viewed the fluid balance charts and according to the charts the person was drinking from between 1,300 mls to 2,025 mls per day for seven days prior to their admission. We noted that in the daily records on the 26 May 2016 they stated the person had 'drank small amounts' but the fluid chart total on that day was 2,025 mls illustrating a discrepancy as the total would not constitute small amounts. We asked to view the multidisciplinary records to establish whether healthcare professionals had been involved but we were informed by the area manager that the multidisciplinary records had not been completed and therefore, there were no multidisciplinary records available to view.

This was a breach of Regulation 14 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider failed to ensure people had access to fluids when needed and to keep an accurate record of food and fluid amounts taken.

Requires Improvement

Is the service caring?

Our findings

We asked people who lived in the care home and their relatives if they were happy with the care they were receiving. One relative we spoke with during our inspection told us "Seen an improvement, staff are now more understanding." Another relative said – "there's been a vast improvement". One person we spoke to who lived there said – "Staff are marvellous"

We observed staff speaking to people in a polite and respectful manner. Relatives we spoke with during our inspection told us they did not have any concerns about the how their relatives were treated within the care home. One relative told us – "the staff are good and I am happy with the way the staff treat X".

We observed people's dignity was not always respected. Furthermore, we also observed people were not receiving support in a timely way to maintain their dignity. The care being provided was task focused with staff rushing from one person to the next to provide care such as taking people to the toilet, assisting people to have a shower, undertaking domestic duties, assisting people to dress. Staff we spoke with said they did not have time to sit and talk to people. We observed staff in the communal lounges busy writing up the fluid balance charts and notes and not having time to engage with the people in the lounge. Staff were unable to sit for periods of time with people and were often pulled away from what they were doing to assist another staff member or another resident. One staff member was seen using their mobile phone whilst people around them required care and attention. We intervened and asked the registered manager to ensure the staff member was asked not to use their phone whilst providing care. The carer was observed sitting away from people whilst using their mobile phone, it was clear they were not interacting with people. The carer said they were 'watching' people. One person we observed who was unshaven was pointed out to the carer. The carer responded "somebody would be shaving them later." This was reported to the registered manager.

People's rooms were not always clean. People who were unable to monitor their own personal hygiene due to their dementia were not receiving care which maintained their dignity. One person had not been supported to maintain personal hygiene and had food down one side of their mouth, neck and top garment. Another person's room had an unemptied commode bucket which staff did not empty for a number of hours after use. There was a strong smell of urine in one person's room where their floor had not been cleaned, also in another person's room which had food across the floor.

We did not find reference to advocacy being sought for people apart from for one person who did not speak English and was assessed by the Local Authority for a deprivation of liberty authorisation. There was an interpreter from the local authority. Whilst we understood in some cases advocacy was needed as part of the deprivation of liberty assessment process by the local authority, we did not see any evidence of advocacy being sought at any other time. This was particularly important for one person who we were told by staff was unable to speak English and had no relatives. They were unable to converse in English but the care home had failed to identify that the person would be at increased risk of isolation with not having anyone to speak with if they wished on a day to day basis.

This is a breach of Regulation 10 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. Staff were unable to provide care which maintained people's dignity due to inadequate staffing levels.

Inadequate

Is the service responsive?

Our findings

We looked into whether people were receiving the care they needed and what activities were available for people in the care home. One relative told us – "Sometimes (resident's) hands and finger nails are dirty, the food is good, like more entertainment, the activities coordinator tries their best but they are only able to provide activities over both floors for one hour each afternoon, I've never seen ill treatment here". Another relative said – "people need more entertainment".

People were not receiving personalised care. For example, one person we observed who sat in the lounge during the day became vocal and agitated during inspection asking for a drink. A staff member explained that the person didn't understand what time it was and therefore, they were unable to keep track of the time or understand that drinks were being brought to the lounge at 11am. The person suffered with Lewy Body dementia. A feature of their type of dementia was that the person could become easily upset or agitated. The staff member said that the person had broken doorframes and raised their hands to others previously. We viewed the care plan and there was no detailed person centred information or risk assessment for staff to be guided as to what the triggers were for the person's agitated behaviour. There was no information regarding the person's likes/dislikes or topics to engage the person. Restricting drinks to a set time was resulting in an exacerbation of the person's agitation and behaviour but this had not been identified as a trigger by staff including the registered manager. We observed the person becoming agitated as they walked out of the lounge in an abrupt manner and tapped another person who was sitting in their chair on their head. There were no staff present in the lounge at this time, placing both people at risk of being involved in an altercation.

This was a breach of Regulation 9 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The care being provided was not meeting people's needs or reflecting individual preferences.

We looked into whether people's care needs were reviewed in a timely way. One person we case tracked who staff themselves identified as someone whose needs could not be met within the care home was found to have not received a review of their care needs. The registered manager told us that they had liaised with a Community Psychiatric Nurse and Consultant Psychiatrist but had not documented the details of their conversations in the records. The local authority were unaware of the deterioration in the person's condition/behaviour. A review had not been requested in order for them to re assess the person's care needs and whether their care needs indicated a higher level of care than was being provided indicating an alternative placement in a nursing care home. Therefore, the care home had failed to respond to people's changing health needs and trigger appropriate reviews for people. We asked the registered manager to request an urgent review from the local authority of the person's care needs. This was undertaken and the outcome from the review was that a nursing placement was more appropriate according to the rapid deterioration and high level needs of the person to keep them safe from harm.

A GP had visited a person at the care home and recommended the person elevated their feet due to high blood pressure until their next visit seven days later. The following day we found the senior staff member

who was present with the GP when this was recommended had failed to document it in the person's care records. Therefore, we found staff were not aware to elevate the person's feet. On another occasion we spoke to a district nurse who had visited another person in the care home. The district nurse told us the person had a chest infection and staff had confirmed to them the person was eating and drinking. When we spoke to the senior carer they could not confirm what type of infection the person had. When we checked the person's records we only found reference to an "infection" in the handover sheet but it was not documented in the care records. We raised concern with the registered manager that the person's changing health needs were not being documented in the care records. Furthermore the person was not being monitored for fluid intake. The registered manager took action and implemented a fluid balance chart. The registered manager explained staff were required to document in the collaborative multidisciplinary section of the care records when health professional advice is sought or received. However, we found the registered manager was not following this practice as they told us they were not documenting conversations they had with health care professionals. Staff were therefore, not receiving adequate leadership and were not being led by example.

We viewed one person's care plan who had been readmitted back into the care home on 13 May 2016 following a hospital admission due to a urine infection. The person then developed pressure blisters on both heels. The care plan had been last updated in April 2016 and according to the records the person was mobile and able to walk. Despite their mobility deteriorating to needing one to two staff to walk the care plan and risk assessments had not been updated according to the change. When we enquired why the person was in bed and was not being supported to sit out in their chair. We were informed by staff that the person had been on bed rest.

We spoke to the registered manager who confirmed they had agreed with the person's family members to place the person on bed rest due to swollen legs. We spoke to the registered manager and raised concerns that the person had been placed on bed rest without clinical recommendation by a doctor or nurse without any pressure relieving mattress in place. Upon reading the records the person developed pressure blisters and was receiving input from the District Nurse from the point at which the staff noted the blisters had appeared. The District Nurse confirmed that they would not have expected the manager to request their approval prior to making the clinical decision to place the person on bed rest but they would expect a positioning chart and the person's heels not to be touching the bed. We did not view any documentation in the person's care plan providing these instructions to staff or a referral for a pressure mattress on the day the decision was made for bed rest. The registered manager told us the person had not been placed on 'full' bed rest and had sat out of bed from 20 May 2016 to 23 May 2016. Referral to District Nurse completed on 24 May16, 2 hourly pressure relief given". We found the person had not been placed on a positioning chart or a fluid chart during our inspection and raised this with the registered manager who took action immediately.

We were also assured a pressure mattress was requested by the District Nurse. When we asked to see evidence of this we were given a form which had been retrospectively written on 31 May 2016. Therefore, we could not be sure this retrospectively written document was accurate or correct. From the daily records we were concerned staff failed to keep the person safe from harm by placing the person on bed rest without a pressure mattress or repositioning chart. The person had been treated for a urine infection prior to being received back in the care home on 13 May 2016 but had not been reassessed whether fluid monitoring was required, despite the policy stating urine infections were a risk factor. Furthermore, there was no evidence of fluid/dietary intake reassessment or monitoring at the point when the person developed a 'tiny blister' on their hip and further pressure blisters on their heels. The service's fluid and nutrition policy dated December 2015 stated one of the risk factors for hydration is urine infections.

We case tracked another person as we discovered they were being treated for an infection. We asked the

senior carer why the person was on antibiotics and they told us 'because of an infection' but they were unable to confirm what type of infection. We spoke to a District Nurse visiting the care home on the first morning of our inspection. The District Nurse told us that the person was being treated for a chest infection. They also told us staff had passed onto them that day that the person was eating and drinking well on the day of their assessment visit. We observed the person had no fluids in their room on the first day of our inspection and a fluid balance chart was not in place for staff to be able to monitor fluid intake. We viewed the daily records and the multidisciplinary records and we were unable to find any entry pertaining to the person being diagnosed with a chest infection. As a result of this we spoke to the registered manager who then took action and implemented fluid intake monitoring. We also viewed the handover sheet which stated 'infection' next to the person's name but no further details. By not keeping a contemporaneous record and through a lack of monitoring fluid intake, this was placing the person at unnecessary risk of harm to their health and wellbeing.

A health professional from the manual handling team who we spoke to told us that they had assessed a person during our inspection at the request of the care home but they highlighted that the referral had not been made in a timely manner and was a month later than they would have liked to ensure the person's needs were met. We therefore were concerned the care home were not always referring early enough to ensure people's changing needs were reassessed effectively.

This was a breach of Regulation 12 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered person had failed to ensure the safe care and treatment of people using the service.

We spoke with the activities coordinator who also worked as a carer at the care home. They were vague about their role and told us that they worked from 12 – 5pm weekdays and started activities at 12pm it was evident that 12.30 – 2pm was meal times, therefore losing 2 hours of activity provision. We observed the activities coordinator assisting with meals at lunch time and other staff told us this was normal practice and there were not enough activities were available for people. The care home had no transport to accompany people on trips outside of the care home. The provider confirmed that when trips are organised the home accommodates this with hired bus services. A relative told us a trip was planned once each year. A singer visited every 2 weeks for an hour. Another visiting relative told us that the activities were poor and when they visited each day they found – 'every day was the same'. Some people were observed wandering without purpose around the care home and on two occasions we saw a person lying down in another person's bedroom. Other people were restlessly touching bare walls, doorframes and radiator covers. We did not see any dementia friendly tools such as memory boxes or memorabilia to keep people moderately stimulated. There were televisions on in the lounges and on the third day of our inspection we observed a newspaper for people to pick up and look at. We found around 12 'Twiddle Muffs' (dementia friendly knitted hand muffs) in the office, when we asked why people were not using them the registered manager and a carer told us they were waiting to make more and have them labelled.

There was an activity plan on display but it was not being delivered. We saw an activity record book of what was available and what people liked however, no evidence of it being implemented. There were no dementia friendly equipment/posters in the home leading to a clinical appearance as opposed to a homely environment for people. NICE England guidance states – 'Guides to the design of residential homes for the care of people with dementia generally recommend creating home-like environments that are domestic and familiar, rather than institutional, in character and there is some evidence that people with dementia benefit from caring environments that are more home-like in character. Environments characterised as having a home-like ambiance have personalised rooms, home-like furnishings and natural elements incorporated into the design. A number of studies suggest that such environments promote well-being among residents,

as they are associated with improved intellectual and emotional well-being, enhanced social interaction, reduced agitation, reduced trespassing and exit seeking, greater preference and pleasure, and improved functionality of older adults with dementia and other mental illnesses'.

We completed a Short Observational Framework for Inspection (SOFI) whilst observing people in the ground floor lounge at 2pm on 2 June 2016. We observed five people out of 10 who were sitting in the lounge. The activities coordinator was observed providing an activity to another two people outside in the garden. The drinks trolley was brought into the lounge by a staff member who was observed placing drinks of orange juice on the tables in front of people with no choice being offered for people. We observed one person who had a drink placed in front of them who continued to watch what was going on around them passively and did not initiate picking up the drink. We saw another person was asleep with a drink placed in front of them. Another person was observed sitting with their head down with a drink in front of them on the table. One staff member was observed supporting people in the lounge to drink. We observed the staff member spending no more than six minutes supporting one person to drink who was taking sips of orange juice from the cup before the staff member then walked across to another person who was asleep and needed to be woken to ensure they were drinking fluids. This demonstrated there were not adequate staffing levels to meet the individual care needs of the people we observed to deliver person centred care.

This is a further breach of Regulation 9 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider failed to provide person centred care according to individual care needs.

We viewed the complaints file and found evidence of some complaints made. There was a system in place for receiving and acting on complaints. The registered manager had investigated the complaints and there was a response seen. However, we found there was no evidence of learning from the complaint so we could not be sure the same thing would not happen again. For example, we viewed a complaint by a relative who stated – "(resident) was very unkempt and had someone else's top on.' The response seen by the registered manager was that they had spoken to the staff and they said there was no reason to change the person's top. The outcome was that the registered manager considered the relative should have said something to the staff. This did not demonstrate that learning had taken place regarding how people's clothes were being mixed up or that a review of the system of labelling clothes was being followed up on. Also, there was no detail mentioned regarding the person being unkempt.

Inadequate

Is the service well-led?

Our findings

Staff spoke fondly of the registered manager and told us they felt supported by them. A relative told us - "(registered manager) is lovely They respect the residents more than the staff". One staff member told us they were concerned the registered manager needed more assistance than they were receiving – "(registered manager) could do with more help, it's too much for them at times". The staff member told us the registered manager doesn't always have 'a full overview all of the time' and 'needs more help to manage things day to day.' Another staff member told us – "good support from (registered manager)." We found there was a system in place for people to provide their views about the service.

On the first day of our inspection we found the rating 'inadequate' was not being displayed. We asked the registered manager why the rating was not displayed and we were informed a person living at the care home had taken it off the wall. We asked the registered manager to display the rating and this was done immediately.

The registered manager had completed an audit of incidents and falls. They had also completed an audit on infection control and had completed supervision sessions with staff specifically on improving infection control practices within the home. The registered manager had also completed one to one sessions with staff to improve practices around hydration and nutrition. Other audits seen (a nutrition audit, call bell audit, weighing scales audit, incontinence audit, first aid kit audit) had been delegated to carers to complete who were given supervision by the manager around how to complete an audit. We were concerned the audits which had been completed were not effective as they had not highlighted the issues found on inspection such as inadequate staffing levels to keep people safe from harm.

The area manager told us they had left the management of the care home to the registered manager but were available to support the manager when needed. We saw evidence that the area manager had visited the care home to undertake their own 'spot check' but we could not see evidence of collaborative working between the area manager and the registered manager. The last audit seen by the area manager was dated 25 April 2016.

We requested an updated action plan from the provider during our inspection. We were concerned when we found the action plan submitted to us had action points and time frames for the registered manager to complete and implement specific things but there had been no consultation with the registered manager as to whether the time frames were realistic. Therefore, we found action points to be achieved by 10 June 2016 had not been implemented. Following our inspection the provider made us aware the registered manager was asked to review and implement the action plan in good time to achieve this.

On the first day of our inspection, we found the office door was unlocked with confidential notes and records accessible to people walking around the care home. We asked the office door to be kept locked when unattended. When we re visited the care home on day three of our inspection we found the office door on the top floor propped open by a fan. There were confidential care records left out on the desk. We brought this to the attention of the registered manager who told us staff knew they were meant to lock the

office door but had failed to do this.

We were concerned the registered manager did not have a full over view of the care home or of how communication systems were failing. We asked the registered manager what was the biggest challenge at the moment within the care home. They responded – "getting the meal times at the right times is the main challenge". From the findings of our inspection there were challenges which had a greater impact for people living there such as staffing levels to maintain people's safety and well-being and people receiving care when they needed it to prevent them from being incontinent or falling.

We asked the registered manager on the first day of our inspection if there were any staff sick on that day who we could expect not to see in the care home who were on the rota. The registered manager told us there were not any staff off sick on the first day of our inspection. However, we found detailed on the handover sheet dated 30 May 2016 that staff had phoned in sick. It transpired the handover sheet had not been shared with the registered manager by the deputy manager. Also written on the handover sheet were details of bruising seen by the deputy manager which had not been reported as a safeguarding. We also found another example in a person's daily records where the deputy had documented – "bruising, how sustained?" but had not reported this or brought it to the attention of the registered manager. We asked the registered manager and the area manager how they planned to deal with this matter and we were informed the deputy manager would be invited into the care home for an initial investigatory disciplinary meeting the following day.

The area manager and registered manager told us they had concerns regarding the deputy manager's supervision of the senior staff in addition to the under reporting of safeguarding incidents. We contacted the care home the following day and spoke to the deputy manager who told us they were acting manager until the registered manager came back from their annual leave four days later. In view of the concerns related to the deputy manager's under reporting of safeguarding incidents and concerns over their effectiveness to supervise senior staff, we were concerned the decision had been made they would manage the care home and be responsible for all the people and staff. We requested the service took action and the deputy manager was then suspended from duties pending investigation. We were informed that the registered manager had not completed satisfactory notes from the initial investigatory meeting. As a result of this we remained concerned about how management decisions were being made.

We found communication systems were failing. These failings had not been identified by the registered manager who was disappointed when the inspection highlighted staff were not passing information on or taking action when they received information in relation to the health and well-being of people living in the care home. One person's daily record entries from 1 to 3 June were missing. When the registered manager looked for the records they were unable to locate them. Therefore, the systems for maintaining accurate and contemporaneous records were also failing.

Although staff told us they were supported in their roles by the manager we were concerned not all staff felt they had what they needed to do their job. We asked the chef if they had all the equipment they required to do their job effectively. The chef and the chef's assistant told us they had a small sized dish washer which was not adequate for the amount of crockery they were required to clean for 48 people throughout the day. They said they washed some dishes by hand and had difficulty with this as they did not have a waste disposal or rinsing facility to ensure the sinks were not blocked. They told us that the drain in the kitchen was checked every six months and the smell was "awful" due to the problems with waste disposal.

We received notes from another home care manager who visited the care home in the absence of the registered manager and deputy manager. They had sent an email dated 4 June 2016 which raised concerns

regarding their findings when they visited the care home. The concerns included that there was a strong smell of urine in the reception area of the care home but nothing had been done to clean this area despite the senior staff also noticing this when they arrived that day. There were no jugs of fluids seen left out for people with only two people in their rooms with a beaker of juice but no jug. The manager made suggestions to improve the incidents file, handover documentation and a communication book.

This is a breach of Regulation 17 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The systems in place were failing demonstrating a lack of leadership and governance.