CareQuality Commission

Ashlyn Healthcare Limited

Ashlyn

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We previously carried out an unannounced comprehensive inspection of this service on 22 April 2016. At that time Ashlyn was awarded a rating of 'Good' overall but was rated 'requires improvement' in the domain of safe due to concerns expressed by people and relatives regarding low staff numbers. Following on from that inspection we subsequently received concerns in relation to insufficient staffing and safe care and treatment of people. We therefore undertook an unannounced night inspection on 8 July 2017.

During this inspection visit we found breaches of our regulatory requirements and as a result of our concerns we wrote an urgent action letter to the provider requesting an action plan to set out how they would deal with the issues we found. We then completed an unannounced follow up visit on 20 July 2017 to complete a comprehensive inspection of the service.

During our inspection we found breaches of Regulation 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of the report.

Due to the high level of concerns regarding the breach of Regulation 9 relating to person-centred care, specifically that people were not receiving regular baths or showers in accordance with their expressed needs and preferences. We served the registered manager and provider with a Warning Notice. This set out where the service was failing and required the provider to address our concerns within a specific time frame.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the Care Quality Commission. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Ashlyn is a residential care home registered to provide accommodation and personal care for up to 60

people. At the time of our inspection visits 51 people were using the service, accommodated on two floors. The ground floor was residential whilst the first floor was occupied by people living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were advised that the registered manager intended to resign and that the deputy manager would be taking over as registered manager in the near future.

The service was failing to provide person-centred care, particularly with regard to supporting people with their personal care and respecting people's preferences around bathing. The care and support people received was task-focussed which met the needs of the service rather than the needs of people. The system employed by the provider to deliver bathing support to people designated each person one day a week to have a bath or shower though in practice this was not happening. We reviewed 30 sets of people's daily care records over the period of a month and found that 26 out of 30 people had not had a bath or shower within that time period though they had received body washes.

At the time of inspection we found there was insufficient staff deployed to safely and effectively meet people's needs. People were waiting extended periods of time for support with personal care, assistance to go to the toilet and being supported to go to bed. This had significantly impacted on people's dignity and wellbeing.

Risks to people were not always well managed. Risk assessments were in place but these did not always accurately reflect the level of risks to people. We found that oversight in communal and private areas to monitor people at night time was cursory and inconsistent and placed people at risk of harm. However, the provider responded positively to the concerns we raised around night time staffing levels and had introduced additional staff during the night shift including a staff member whose role was to remain in the communal lounge to provide constant supervision and support to people.

There were quality assurance mechanisms in place to measure the quality and safety of the service but these had been ineffective as they had failed to pick up and address many of the issues we had found, particularly around staffing and personalised care. A lack of managerial oversight meant that some people living at the service were experiencing poor care and support which neither met their needs or reflected their preferences.

Mechanisms to provide staff with training and supervision, and appraisals were in place to support staff to be effective in their role. However, staff did not always feel supported as felt they lacked leadership, direction and guidance. As a result staff morale was low. The provider had responded to this issue with the appointment of a quality lead whose role was to coach and mentor staff and introduce a leadership programme for senior members of staff. However, it was too early to measure the impact as this was not yet embedded in practice.

People had access to healthcare services and treatment however improvements were required in terms of information sharing and recording practices to ensure that any advice and guidance provided was known and acted upon by staff.

Staff were kind and friendly and knew people well. However, improvements were needed to ensure peoples dignity was always respected and promoted.

During our initial visit we found people on the first floor had not been supported to have enough to drink. However, on our second inspection visit we found people had drinks within reach and regularly topped up all day and fluid charts indicated that people were receiving enough fluids. This demonstrated that the provider had addressed the concerns we had raised regarding people's hydration needs.

There were activities available for people to take part in with a structured weekly activity programme and visits from external entertainment and events were organised. However improvements were needed in the way the service and staff supported people living with dementia to participate in activities of their choice and ability. There was a lack of opportunities for stimulation and one to one engagement between staff and people, particularly for those living with dementia.

There were policies and procedures in place to manage complaints. People and their representatives were also invited to voice their opinions and raise any concerns through satisfaction surveys and regular resident and relatives meetings. However, improvements were required in how the service responded to people's comments and complaints so that people felt listened to and to ensure issues raised were actioned appropriately.

People were supported to have enough to eat and told us that the food was very good. Mealtimes were a positive experience for people with lots of choice available and staff on hand to provide assistance with eating if required.

Staff had received training in safeguarding people from abuse and knew the signs to look for and how to report their concerns. They were aware of the whistle-blowing policy and said they would feel confident to speak up if necessary to keep people safe.

There were robust systems in place to ensure the appropriate management of medicines and people received their medicines safely. Recruitment processes were also robust to ensure staff were recruited safely.

The service was meeting the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Appropriate mental capacity assessments and best interest decisions had been undertaken. This ensured that any decisions taken on behalf of people were in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated codes of practice. Staff had received training in the MCA and supported people with decision making and involved them in choices about their care and support. People's consent for day to day care and treatment was sought by staff.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were made welcome at the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not always well managed.

There were insufficient staff deployed to safely meet people's needs.

Medicines were managed safely.

Staff were aware of their safeguarding responsibilities and how to report abuse.

Staff had been safely recruited.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Teamwork was incohesive and staff did not always feel supported and lacked leadership and direction which meant staff morale was low.

Improvements were required in supporting people to have their healthcare needs met effectively and in a timely manner.

People were supported to have enough to eat and food was of a good quality.

The provider was working within the legislative guidelines of the Mental Capacity Act and Deprivation of Liberty Safeguards and staff knew how to help people make decisions and the importance of asking for consent.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and friendly but did not always have time to spend with people.

People's dignity was not always upheld.

Staff listened to people and knew them well.

Is the service responsive?

Inadequate

The service was not responsive.

Task focussed systems and practices meant that people did not receive person-centred care.

The service supported people to have things to do but work was required to make activities more meaningful and inclusive for people living with dementia.

There were systems and processes in place to respond to complaints but in practice, complaints were not always managed well.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance mechanisms were in place but these had failed to identify some of the concerns we had found.

A lack of managerial oversight meant that some people living at the service were experiencing poor care and support which neither met their needs or reflected their preferences.

Staff did not always feel listened to or included in the running of the service.

There was recognition that a change in management style, systems and processes and support mechanisms for staff was required to drive the necessary improvements.

Care Quality Commission

Ashlyn

Detailed findings

Background to this inspection

In response to information of concern we had received regarding the safe care and treatment of people we carried out an unannounced comprehensive inspection of Ashlyn under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was 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.

The night inspection on 8 July 2017 was undertaken by two inspectors. The following comprehensive inspection on 20 July 2017 was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed all the information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events, which the provider is required to send us by law. We also reviewed information received from relatives of people who used the service and information shared with us by the safeguarding and quality improvement teams of the local authority.

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.

Over the course of our inspection visits we spoke with the regional manager, deputy manager and the quality lead and ten care staff and two domestic staff. We spoke with two visiting professionals, twenty people living in the service and four relatives. We reviewed various documents including seven people's care records, four staff files and other relevant documentation such as training records, quality audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

At the time of the inspection we had received information of concern about whether people were receiving safe care and treatment at the service, particularly at night time. Areas of concern included insufficient staffing numbers to monitor and support people safely and concerns around how risk was managed including risks of falls and risks associated with poor hydration.

On our first visit which took place at night-time we saw there were two staff on each floor plus a further member of staff whose role was to float between the two floors providing support where necessary. Staff told us that in practice this did not generally happen as the 'floater' was always required upstairs to support the staff on the first floor which accommodated people living with dementia.

On the first floor we saw that staff worked hard to support people and keep them safe however there was insufficient staff deployed to safely meet the needs of people who used the service. For example, people identified at risk of falling did not receive the supervision and monitoring they required to help keep them safe. One person who was at risk of falls tried to stand and move around without assistance or supervision on several occasions. Twice a senior member of staff on duty noticed and came to their aid. However at other times an inspector had to intervene to support the person to safely sit back down. This person had been identified in their care records as requiring support from two members of staff. Their care plan stated, "If [person] is trying to stand and get up independently then two members of staff need to assist." We observed four separate occasions where they stood up or moved around without supervision whilst staff were busy supporting other people.

Due to low staffing numbers in the lounge area, people's emotional wellbeing was not well managed at night. During the evening inspection, we observed that people in the first floor lounge became increasingly more anxious when staff were not present, often calling out in a distressed state for staff assistance. One person called for staff on at least three occasions, crying out, "I am doing it in my knickers, sorry nurse could you forgive me I could not stop myself." And, "I cannot call anyone." And, "Is there someone helping?" And, "Nurse, Nurse." We saw that when staff were able to attend to people the interactions were positive and staff did their best to reassure people and alleviate their anxiety however staff did not have time to remain in the lounge for any sustained periods of time.

On the ground floor, people that were able to speak to us told us there was not enough staff. One person told us they were told by staff only to use the buzzer for emergencies but they were not clear what constituted an emergency. Another person told us they used their buzzer but no one ever came. A third person told us that the service was always short staffed as cover was not always available when staff called in sick. One person told us they were very tired and would like to go to bed but staff were not available to help them to do so.

There were 28 people living on the first floor floor. Staff told us that 20 of those people required two staff to support them. When we arrived to complete our inspection at 9pm we saw that in the lounge, 20 out of 28 people still required support to retire to bed. Staff told us that because of low staffing numbers they did not

finish supporting people to retire to bed at night until around midnight on the ground floor and 1am most nights on the first floor.

All of the staff we spoke to told us that there were not enough staff at night-time which was due to the high needs of the people using the service, the majority of whom required two members of staff to assist them. We were advised by staff that this was the reason that a lot of unwitnessed falls occurred at night. One staff member told us, "I have to do medication which can take up to an hour so there is only two staff available to support people, today one member of staff is late so there has just been two of us until now."

Following on from our night visit we wrote an urgent action letter to the provider setting out our concerns and requesting an immediate action plan. In response the provider recruited an additional member of night staff and introduced a trial of additional members of staff at key points in the evening and early morning to provide additional support for people.

During our second day of inspection, which commenced at 7am whilst the night staff were still on duty, we received feedback from staff on the first floor that the situation had greatly improved. Staff told us there was an extra night staff person on duty responsible for monitoring the lounge area and that things were much better. We were told various members of the management team had come in overnight to assess the situation. As a result there were now five staff upstairs and staff felt finally the issue had been recognised.

However, we found that staffing deployment was still considered to be an issue of concern during the day by staff, people and relatives. The reasons provided were; a lack of manual handling equipment; too many forms for staff to fill in taking staff away from people and ineffective contingency plans for cover for when staff called in sick or were absent. One staff member told us, "If some-one doesn't come in, we don't always get a replacement, yet the expectation is to perform the same." Another said, "We don't have the resources and staff to manage the high needs of people here." Another told us, "Recently we only had three staff on during the day and three at night, people were sick and we couldn't get staff." Comments from people included, "When I ring the bell for going to the toilet the staff come and say 'we will be back to see to you', but they take a long time and by then I have wet myself. That is why I do not like going to the lounge now because if I call for the toilet and no one comes I wet myself and that is not very nice for me." And, "I often have to wait for the call bell to be answered, and then you are told, 'to wait as we have others to see before you' but the girls are kind it is not their fault if there are a lot of people that need help." And, "The staff cannot always come to you straight away when you ring as they have a lot of us to help". And, "You wait a long time for call bell to be answered most of the time but the staff are so busy." The lack of resources had impacted on people in a number of ways such as not being supported to go to the toilet when needed, being helped to bed when they wanted or being able to have a bath or shower.

We spoke to the management team about these on going concerns. They advised us that they had ordered an additional hoist so that staff could support people in a more timely fashion. In addition, they were looking at how staff were deployed and supported to become more effective at supporting people in a timely manner as well as reviewing the current system of recording practices to try to minimise the amount of time spent completing paperwork for staff.

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

Risks to people were not always assessed and managed safely. For example, on our first visit we found that insufficient information was provided to staff for them to safely meet the needs of a person that had been admitted to the service. We were unable to locate a care plan or risk assessments for this person to support

staff to care for the person safely. Staff told us they had received a very brief verbal hand-over from day staff telling them the person's name and that they were a nice man who was at high risk of falling. There was no management plan in place for how to manage any risks to this person and we saw them left unsupervised in the lounge area for the duration of our visit. We highlighted this concern in our urgent action letter to the provider and on our second inspection visit we saw that the paperwork had now been completed.

During our first visit we found that people were not always provided with drinks to minimise the risk of dehydration and urinary tract infections which are prevalent in older adults living with dementia who may forget to drink. Staff told us that a new monitoring form had been introduced on the day of inspection that instructed staff to offer or enable people to have a drink every hour and record what people had drank. However, staff told us this task was not possible in the time they had which meant they were unable to support people on the first floor to remain hydrated. During this inspection over a two and half-hour period we saw that ten people were not offered a drink or had a drink available.

Our concerns regarding people's hydration were also set out in the urgent action letter to the provider. On our second inspection visit we observed that people had hot and cold drinks provided to them in the morning and throughout the day which were within reach and topped up regularly. We reviewed seven people's fluid charts and saw that all but four had met their hydration targets to support them to remain well. During the morning handover the four people that had not reached their target were discussed to highlight risks to people and how to manage them.

Staff told us that people received hourly night checks to monitor people's safety and wellbeing. However we found these had not always been completed or recorded. We had received a safeguarding notification that was raised by the ambulance service when called out to a person who had become unwell. Concerns were raised that the person had not been regularly monitored throughout the night. We spoke to the registered manager who provided us with an investigation report which confirmed that the person had not always received their hourly checks. We were advised that the staff concerned had been disciplined as a result.

Staff informed us that they did not have sufficient time to complete night checks until they had supported people into bed which was usually around 1am. This meant that people who retired early did not always receive an adequate level of supervision and monitoring. One person was seen by an inspector sitting alone on a hard chair in the dining room in the dark. The lights were off and the person was asleep slumped over the table. When questioned staff were not aware of the person's presence in the dining room, as the hourly night checks had not yet commenced. This person was still there at 11.30pm when we left.

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

We found that the storage, administration and disposal of medicines was undertaken safely and in line with current professional guidelines. There were robust systems in place to manage people's medicines safely. Staff confirmed and we saw evidence that only the senior staff who had been trained and assessed as competent administered people's medicines which were dispensed from a locked trolley. People had individual medicine administration records (MAR) sheets which had been completed correctly and there were no omissions of the staff signatures. All loose medication was checked daily to monitor that people had received their medicines as prescribed. We completed a stock count of people's loose medications, all of which balanced. Staff told us that a medicine audit was completed three times a day using a comprehensive daily audit tool. In addition a twice daily check sheet was completed to ensure medicines were managed safely.

There were systems in place to protect people from the risks of abuse. These included staff receiving

training in safeguarding vulnerable adults and they were able to describe to us how they would recognise the different signs of abuse. Staff were aware of the correct processes to follow in order to report abuse. There was a whistle-blowing policy in place which staff were aware of and told us they would whistleblow if required. Staff comments included, "I would go straight to head office to report abuse and CQC." And, "If I thought I wasn't being listened to I would take it higher." Prior to our inspection we had received whistle-blowing notifications from staff evidencing that staff were aware of their whistle-blowing responsibilities and would act to report poor practice.

Safe recruitment processes were in place for the employment of staff. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support.

There were arrangements in place to manage and maintain the premises and the equipment both internally and externally. We saw that the relevant health and safety checks, maintenance, fire drills and equipment and water testing had all been completed.

Requires Improvement

Is the service effective?

Our findings

Staff reported that their experiences of working at the service, how supported they felt and the sense of teamwork within the service varied from day to day. One staff member said, "It's a good day today as we have a good team on and we are working well together." Another said, "Some days it is good and some days it is bad." One staff member described the issue as; "It's a mix of not enough staff, not the right skill set; some staff need more direction and leadership from senior management, some seniors are hands on and some are not." This variability and the subsequent low morale of staff had impacted on the effectiveness of the service people received. This was summed up by one member of staff who said, "Staff morale has been very low and unhappy staff means unhappy residents."

We spoke to the quality lead about the concerns expressed by staff. They told us that these issues had been recognised by the provider and that in response they had been brought in to provide coaching and mentorship to staff and deliver a leadership programme to senior members of staff. We saw evidence of how this role was being used to develop staff knowledge and skills during a seniors meeting where there was a discussion about a person being changed to a soft diet. The quality lead took this opportunity to educate staff regarding the risks of choking.

Records showed and staff confirmed that they had received an induction when they joined the service which included completing mandatory training and shadowing existing staff so they could get to know people and their care needs. Staff told us they completed an on-line version of the Care Certificate as part of their induction process. The Care Certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care and is considered best practice as a way of inducting new staff into the caring professions.

Staff received supervision to support them in their role and identify any learning needs and opportunities for professional development. An electronic tracker was used to monitor staff supervision to ensure it was completed regularly. We looked at the tracker and saw that the majority of supervision was up to date. We looked at four staff records and saw that staff had received a mixture of one to one supervisions and observations of practice to assess staff competencies. We saw that where a person had expressed an interest in further training in dementia the service had arranged for them to become a dementia champion. We also saw that supervision was used to address gaps in knowledge. For example, where it had been picked up that a staff member had made a mistake with managing people's medicines, the staff member was supported with re-training and coaching.

We received mixed feedback from staff regarding the regularity and quality of supervision. Some staff said they received supervision every two months, others every six months whilst night staff reported that supervision was patchy and inconsistent. One staff member told us, "I get supervision three monthly; [quality lead] did the last one, they are very approachable."

Staff received on going training to support them in their role and were encouraged to undertake further advanced qualifications if they chose to. Some staff told us they had been supported by the service to

complete level 2 and level 3 health and social care qualifications. The service kept a training matrix to monitor that staff training was up to date and identify when refresher training was due. Email reminders were sent out to staff to ensure training remained current.

Over both days of our inspection we observed how staff managed people's behaviours that could be perceived as challenging. We found that staff diffused situations really well but their interactions with people were brief. Staff were not always present in the areas where people were exhibiting distressed or agitated behaviours. We saw that one person was involved in verbal interactions with other people that had the potential to escalate. None of the staff members seemed to have the time to remove the person from the situation, for example, by going for a walk with them, or sustain any interactions with them.

Some people told us they felt supported to have their health needs met. Comments included, "If you have a hospital appointment a member of staff would go with you." And, "If you need to see a doctor they will arrange it for you." However, two relatives expressed dissatisfaction with the level of health support their family members received. One relative told us that they felt communication was poor from staff and management around health appointments which meant they were unsure whether their family member had received the care and treatment they required. Another relative said that their family member had gone into hospital and would not be coming back to the service due to poor health care treatment their family member had received.

Electronic care records showed that people had been supported to attend appointments with health professionals, such as chiropodists, opticians, and GPs. However, we found poor recording practices relating to health and social care professional advice and visits. In the four care records we looked at there was some evidence documenting that referrals had sometimes been made but a lack of follow up information relating to whether the visits took place, any actions recommended or guidance provided and outcomes for people. A recent investigation by the registered manager had also identified that hand-over of medical advice during shift change was not always robust.

We received mixed feedback from healthcare professionals regarding how effective the service was at following any health guidance provided. We observed that people's healthcare appointments were discussed at the morning hand-over meeting however this lacked detail and guidance for staff. For example, the handover given was that "the bloods are being done this morning." This didn't tell staff what preparation might be required, whether people needed to be positioned in any particular way or to ensure they had something to eat and drink beforehand.

We spoke with the management team about our findings. They told us that there had been some confusion and misunderstanding regarding the current systems and processes for referrals and they had not realised that after people had an admission to hospital, the service would have to re-refer people. There was recognition that recording practices for healthcare required improvement and this had been identified by the management team and an action plan had been implemented to make the necessary improvements.

The service supported people to have enough to eat and the food was of a good quality. Meals were prepared by the chef and served by staff who all demonstrated an awareness of people's likes and dislikes. We observed lots of positive interaction from the chef who came in at 7.30am and chatted to people and knew their names. This continued throughout breakfast where we saw the chef laughing and joking with people.

The feedback we received from people and their relatives was universally positive. Comments included, "I love the food here, it is very good." And," We have fresh vegetables not frozen." And, "We have homemade

ice cream here." People told us they were given a choice of what they wanted to eat and if they didn't like what was on the menu they would be offered an alternative. One person told us, "The food is very good you can have more or less what you want to eat." Another said, "I did not want much to eat today I fancied a cheese sandwich so that is what I had, they did try and get me to have something else but I did not feel like it".

A member of staff told us, "The proper breakfast starts around 8am but before that people can have a snack such as toast or biscuits." We observed two people watching breakfast TV before 8am and saw a member of staff made them tea and toast, offering them the choice of honey or jam. Staff were gentle and skilled in offering choice. Another person, who had been up when we first arrived at 7am was eating cereal, juice and tea in their room. A member of staff told us with enthusiasm, "They are on their second bowl. They don't like eating much at lunch so we make sure they have a good breakfast."

We observed the lunch time dining experience on both floors and it appeared that people enjoyed their meal time. There was laughter and chatting to each other, and staff communicated with people well and ensured that people who required support with eating and drinking received this. Fluids were encouraged and a range of condiments were available. Food was nicely presented with fresh vegetables. People living with dementia were shown the different plates of food to help them make a choice and were provided with an appropriate level of assistance to support them to have enough to eat and drink. We saw that staff appeared to know people's likes and dislikes and gave encouragement where needed.

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 Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the Act, and whether conditions on authorisations to deprive a person of their liberty were being met. We found that the registered manager understood when an application for DoLs should be made and we found the home to be meeting the legal requirements.

Staff told us they had received training in the MCA and training records confirmed this. We found completed mental capacity assessments in people's care plans demonstrating that the service had considered people's capacity and involved people and professionals in decision-making. However, whilst mental capacity assessments had been completed, sometimes, relevant information was missing from the assessment making it difficult to establish whether the legislation had been followed. For example, one person had a mental capacity assessment for bed rails but this did not record whether any health care professionals had been consulted. However in the person's notes we found that an occupational therapist had been involved in the decision which was an appropriate course of action but this had not been recorded in the assessment.

Staff we spoke with were able to demonstrate how they applied the principles of the Act in their daily practice to support people who had difficulty making decisions by giving them choices and communicating in ways that helped people to understand what was being asked of them. One staff member told us, "We show choices to people and give them options."

People told us that staff asked permission before supporting them. One person told us, "The staff know I like

a bib on when eating to keep me clean so they always ask if I would like one on." Another said, "They do ask me what I would like to wear each day and will give you a couple of items of clothes to choose from."

Requires Improvement

Is the service caring?

Our findings

Feedback from people and relatives about staff was that staff were kind and friendly but that they did not often have time to spend with them to engage in meaningful or sustained interactions. Comments from people included, "Sometimes staff talk to you but not a lot, but I think that is because they are pushed for staff here" And, "Some staff do talk to you, other just don't." And, "The staff are friendly and kind but they do not have time to sit and talk to you on your own." And, "The staff are very nice, despite being busy they will have a laugh and joke with you." We observed that domestic staff talked to people as they worked. One domestic member of staff told us, "I love working here because as I go around I can spend some time with the residents and I do love talking to them and getting to know them".

People told us they were treated courteously by staff who knew them well. One person said, "Staff treat me well, I could not ask for better; they do work hard for very little but are always polite to me." Staff were aware of the importance of knocking on doors before entering, calling people by their preferred names and asking permission before providing any care or support. However, despite staff familiarity with people and their awareness of the principles of respecting people and promoting their dignity, inadequate deployment of staff meant that people's dignity was not always upheld. We found that some people had to wait extended period of times to be supported with aspects of their personal care such as bathing, shaving or using the toilet. This had caused some people to experience poor body odour or become incontinent of urine which compromised their dignity and wellbeing.

We observed various occasions where staff supported people with moving and positioning using mobility equipment such as wheelchairs and hoists. On a positive note, staff appeared competent using the equipment and explained to people what they were doing and reassured them. However, we noted on two occasions that there was a lack of awareness about protecting people's modesty as their clothes had risen up and they were not appropriately covered up. There was also a lack of awareness of the potential impact on people of spending long periods of time seated in wheelchairs. On our first visit we observed a person sitting in their wheelchair all night who was mostly dozing. Staff told us they like to go to bed last after all the ladies had been helped to bed which was usually around midnight. We looked at their care records and saw that this information matched what was written in their care records. However, there was no indication that this person wanted to sit in their wheelchair all night so could have been transferred into a more comfortable arm chair. We later learned that this person had a pressure ulcer on their buttocks which can be exacerbated by sitting in a wheelchair for extended periods of time.

During our observations on the first floor, we noted that the interactions between people and staff were friendly and respectful. Staff greeted people with a smile, made eye contact when talking to people and used positive touch to connect with, or reassure people throughout the day. However, interactions were not sustained. Staff we spoke to told us that they had so many tasks to complete they did not have time to sit and chat for long with people.

On our second day of inspection we attended a seniors meeting at which time there was a discussion about a person's diet following a visit from speech and language therapy. Staff discussed meal time options for the

person who had been put on a soft diet. One staff member expressed sadness that the person would no longer be able to have their boiled sweets and cake. There then followed a very caring discussion which established that they would mix the person's cake with cream so they could still enjoy their favourite foods.

Staff were able to demonstrate that they knew people well and listened to them regarding how they liked their care and support. One staff member told us, "People are individual and different, for example one lady does not like anything near or on her radiator and has to have her curtains a certain way." The staff member had learnt this through getting to know the person as the information was not recorded in their care plan. The staff member also told us, "We knock on doors, keep doors shut and I always make sure ladies have a bra or vest on. Most people only get a shower if they are incontinent but we do body washes daily. I make sure people use deodorant and perfume if they choose."

Because people's care records were electronic it was difficult to see whether people had been included and consulted in decisions around their care and support as people had not signed consent forms to evidence their involvement. However, people and relatives told us that they had been included. One person told us, "Yes I have a care plan and it has been updated." A relative also said, "My mums care plan has been discussed and has been updated." We were advised that the service employed a 'Resident of the Day' scheme as a means of ensuring that each person who used the service had a monthly review of their care and support.

People were supported to maintain relationships that were important to them. Relatives told us they were welcome at the service. One relative said, "I can visit at any time, but they do like you to try and avoid meal times." Another said, "I can visit any time here, and if you want a meal you can book one."

We saw that there had been discussions with people regarding their preferred priorities for care which included decisions about their end of life care. Do not attempt resuscitation forms (DNARS) were in place for people though we saw that these did not always hold accurate information. For example, one person's DNAR stated that there had been a discussion with the person's daughter about the decision; however this person did not have any living relatives.

Inadequate

Is the service responsive?

Our findings

We found that the service was failing to deliver care that was person-centred. Person-centred care means providing care and support that is tailored to meet people's individual needs rather than taking a task-based approach which fits with the needs of the service. Staff told us that because of low staffing numbers and the large amount of systems and paperwork in place they were not able to provide person centred care. Comments from staff included, "Care is a bit robotic, all care needs are met and it is overboard for toileting and fluid. We toilet people from a list, we just work down the list; we have to record every drink. There is nothing individual about it, just ensure that people do not go more than four hours without going to the toilet." And, "I think people get good physical care but no time for much else, it can feel like a conveyor belt especially with toileting, when we get to the bottom of the list we just start again at the top." And, ""I feel like I can't give my all to people, it's not person-centred here at all."

We found that people's preferences were not always known, recorded or upheld. During our first visit which took place at night, staff told us that because of low staffing numbers they did not finish supporting people who lived on the first floor to retire to bed at night until around 1am most nights which did not reflect people's needs or preferences. We saw one person sleeping in an arm chair in the lounge in an uncomfortable position; they remained in this position for the duration of our visit and were not supported to go to bed until 1.15am. We reviewed their care records which had recorded their preference for bedtime which was between 9pm and 10pm.

On the ground floor staff advised us that they usually finished helping people to bed by midnight. We found that where people were able to express a preference or able to manage independently, people went to bed and got up when they wanted. One person said, "It's my choice to go to bed, they asked me if I wanted to go and said it's my choice." However, where people struggled to express a preference their experience was not so positive. We observed one person calling out from their room, "No, no I don't want to lay here." Staff tried to reassure the person and settle them in bed but this was not effective so after twenty minutes they hoisted the person into an armchair in their room and gave them a drink and put the television on after which time they appeared calm and settled. We saw six people in the living room of the ground floor with the last person being helped to bed at around 11.45pm. Two of these people were asleep and one told us, "I'm tired I wold like to go to bed." The other three people were unable to tell us whether it was their choice to be up or not.

Seven people that we spoke with during our inspection provided feedback that their needs and preferences around personal care including bathing/showering and support to go to the toilet were not being met. Comments from people included; "I can only have a shower when I'm asked." And, "I only get a shower once a week, I would like more than that but there is a shower chart here." And, "My shower day is Saturday but the district nurse came so I didn't get my shower. I asked if I could have it on Sunday and they said I could if they were not too busy." Two other people told us that they had missed their bathing days but had not been offered an alternative and would have to wait another week.

The system employed by the provider to deliver bathing support to people was not person-centred and

designated each person one day a week to have a bath or shower though in practice this was not happening. We reviewed 30 sets of daily care records within a time frame from 20 June to 20 July 2017 and found that 26 out of 30 people had not had a bath or shower within that time period though they had received body washes.

People's needs had been assessed prior to their admission to the home, and these assessments were used to develop their care plans. Care plans contained some information about people's background and life history but this information was not very detailed and not always accurate to support staff to provide person-centred care. A section of the care plan was titled "All about me" but the information recorded was inconsistent and in three of the care plans that we looked at this section was blank. Care plans we looked at showed evidence of routine monthly reviews, but whilst reviews did identify some changes, many of the entries did not update all sections of the care plan.

Experienced staff we spoke with were able to demonstrate that they knew people well and were aware of their preferences. This information was not held in peoples care plans but was learned over time through getting to know people. This meant that new staff or agency staff without experience of people would not have access to sufficient information to help them provide person-centred care.

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

At our previous inspection there were no specific activity staff employed, however at this inspection we were informed there were two activity members of staff who alternated working at the service. We saw there was a weekly programme of structured activities in place. On the day of inspection we saw there was bingo on in the morning downstairs on the ground floor. People in the first floor lounge were asked if they wanted to attend but those that chose not to, had nothing else to do. However, therapy dogs were brought up onto the first floor in the afternoon. We saw people laughing and smiling and enjoying petting the animals. One person told us, "We have a man come in here once a week and he brings two little dogs in with him and we can hold them."

There was evidence of joined up working between staff to improve the quality of activities people could enjoy. For example, the chef told us, "I work very well with the activity staff, we are currently planning a picnic out, a pie and mash lunch and a country and western music day".

Staff told us they did not have much time available to spend with people. One staff member said, "There is not enough time for activities, but hopefully the activity person will come up this afternoon." However, we did see incidents of staff engaging in ad hoc activities with people when possible. For example, we saw a staff member doing some arts and crafts with a person. They told us, "I am doing colouring with this lady because I have a bit of time and she likes to sit in the dining area."
People also told us that staff did not have time to spend time with them doing things they liked. One person said, "I wish staff had more time to chat with me." Another told us, "My DVD broke and the maintenance man bought me one in, I love playing on my play station as well, but staff do not have time to play with me."

In the first floor lounge we saw a lack of interaction between people and staff. Some people were asleep and three people were seated so that they were looking at the wall. Chairs were not always positioned well for some people to even look at the television if they wanted to. We found that the environment was not particularly 'dementia friendly'. There was a lack of stimuli such as rummage boxes, pictures and objects for reminiscence to engage people's interest and stimulate conversation between staff and people.

We spoke to the management team about the lack of personalised activities for people living with dementia. They told us that this had been recognised in their action plan and there were plans to hold meetings with the activity staff to talk about implementing more structured one to one time for people who were not able or did not want to join in group activities.

The service had a complaints policy and procedure in place and an easy read complaint leaflet was available. We saw that all complaints were logged and responses were to be provided within 28 days. We saw that most responses were completed within this deadline and that the responses were courteous and apologies given where necessary. People and relatives told us that if they had any concerns they would talk to a member of staff or the management team. However, the feedback we received regarding how complaints were dealt with by the registered manager was not positive. One relative told us, "I did complain my mum did not have regular bath or shower but it has not improved." Another told us that they felt communication from the registered manager was poor and that they had not received a response within the time frame specified by the policy. Another person told us that they found the registered manager approachable but that the response provided to their concerns was dismissive. We were advised that in one instance, the quality lead had been asked to take over managing a complaint as the relationship between the complainant and the registered manager had broken down.

Inadequate

Is the service well-led?

Our findings

Registered providers have a statutory duty to make sure that they have effective governance systems and processes in place. This includes assurance and auditing systems which assess, monitor and drive improvement in the quality and safety of the service including the quality of the experience for people using the service. The processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.

We saw that there were a large number of audits and checks in place which were completed regularly, with structured mechanisms for reporting to the senior managers within the wider organisation. However, these checks had failed to address the concerns we had found, specifically in the area of staffing and personalised care. We noted that the checks on the quality of the service were largely based on auditing the paperwork in place. The quality assurance processes failed to effectively measure the experience of the people being supported at the service.

The focus on paperwork meant there was a lack of oversight based on observations of the care being provided. Therefore, whilst there had been a number of night time checks, these had not picked up that people were not being supported to go to bed at a time of their choosing. Likewise, audits had not picked up that people were not being supported to have a bath or shower in line with their preferences. Where audits examined people's experience it was unclear how this was being measured. For example, we saw a recent audit was carried out by the registered manager which stated that people were being supported in line with their preferences, however it was unclear how this had been established.

The measures in place to determine staff deployment and numbers were not adequate to ensure people's needs were met. Calculations of people's dependency were carried out to determine the deployment and numbers of staffing numbers, however these had not proved effective. The quality checks and oversight in place had not picked up that people's needs were not being effectively and safely met.

We found that the provider had implemented paper based solutions to problems. These had been ineffective at addressing the issues we found within the service and in some instances compounded the problems. The amount of paperwork and form filling introduced that staff were required to complete had an adverse effect on the service as it had a negative impact on staff morale and took staff away from the job of caring for people.

Staff feedback provided clear evidence that morale was low and staff felt burdened by paperwork and a lack of time and resources which limited the amount of time they could spend with people. Staff felt they were not listened to and included in how the service was run and that there was a lack of communication between themselves and management. Comments from staff included, "We got new paperwork and rules, when it wasn't working we were getting blamed for it." And, "There's too much paperwork, I came in one day and found out everyone is on a fluid chart, not sure why." And, "We have a daily meeting, no-one asks our opinion, the meeting just tells us what to do. I suggested once it would be nice if we were thanked occasionally. The only person that has ever done that was [quality lead]." And, "I have brought staffing up

before with the manager and regional, I was just told there is enough."

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

We received mixed feedback from people and relatives regarding the approachability and visibility of the registered manager. A person told us, "I know [deputy manager] but I don't know who the overall manager is." A relative said, "[Registered manager] never leaves their office, I don't think they know any of the residents names." However two people told us they thought the registered manager was approachable and nice.

Feedback from staff regarding the accessibility of the registered manager and whether they felt listened to was not positive. One member of staff told us, "I have hardly spoken to the manager apart from when I went to them with a complaint, I think they did sort it, but they do not really have an open door and I don't think they would even know residents names." Another said, "Are management supportive, yes and no; the deputy can be supportive. When [deputy] is upstairs it's good. The registered manager is not hands on and staff don't want to ask them things."

Staff told us they were included in the running of the service through team meetings. However, staff told us they did not always feel confident to express their opinions. One staff member said, "We have a staff meeting every few months but we don't want to speak up." Another said, "Some seniors are afraid to talk to the registered manager because of authority."

Meetings were also held for people and relatives so that they were included in the running of the service. We saw minutes of residents and relatives meetings which occurred regularly and were well attended. These meetings were used to talk about any improvements taking place and give people an opportunity to express concerns. Actions required were recorded however these did not always fully reflect the extent of the root cause of problems or provide the necessary reassurance for people. For example, where two people had raised concerns about delays in being supported with personal care. The action recorded in the notes stated, 'purchase another hoist.' Whilst a lack of mobility equipment may have been a contributing factor to delays in people receiving personal care this was not a full and open response to the issues we had found, that is to say, low staffing levels and a lack of guidance and leadership for staff. This demonstrated a lack of oversight on the part of the registered manager.

Whilst feedback indicated that the current registered manager was not always viewed as a visible presence within the service this was mitigated in part by the fact that the deputy manager was very 'hands-on' providing support to people and staff. Feedback regarding the deputy manager from people and staff was very positive. One staff member said, "[Named] is very approachable and tries to do their best; they are very hands-on and will always come and help." Another said, "The deputy is approachable, they care a lot."

We also received positive feedback from staff regarding the quality lead who had been brought in by the provider in response to concerns raised by the local authority in April 2017. The role of the quality lead was one of coaching and mentorship of staff and we saw that this had already begun to have a positive impact. Staff reported feeling very supported by the quality lead who had met with them to ask for their opinions. Staff told us morale was improving and that they now felt listened to and thought things were changing for the better. One staff member told us, "I now find management approachable, if I had a problem I would go and talk to someone, [quality lead] has had a very positive impact; morale has been low but it's improving now." We found the quality lead to be an enthusiastic and committed addition to the management team and their appointment indicated a positive investment by the provider in addressing the concerns at the service.

On the day of inspection, the registered manager was on annual leave, we therefore spoke to the quality lead, deputy manager and regional manager about our concerns. We were advised that the current registered manager had resigned and that the deputy manager would be taking over as registered manager in the near future. There was recognition that a change in management style with a greater focus on working with staff rather than introducing more paperwork could support staff and help to address concerns.

We saw that an action plan had already been formulated which had identified some of our concerns, such as the inconsistencies in recording health issues for people and the fact that people on the dementia floor lacked stimulation and required more one to one intervention. The action plan also focussed on staff learning and development to support senior staff to improve their leadership skills and become more effective in their role.

The management team also recognised that improvements were required in terms of delivering person-centred care. The deputy manager told us about new initiatives they planned to introduce such as a quiz for staff to test and improve their knowledge of the people they supported. There were also plans to develop a checklist which would be completed on a daily "walkabout" to pick up on any areas that needed addressing immediately, such as if a person looked unkempt.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was failing to provide person-centred care. People's preferences were not always known, recorded or upheld. Care practices were task-focussed and met the needs of the service rather than the needs of people. People had not received regular baths or showers in accordance with their expressed needs and preferences.

The enforcement action we took:

Warning Notice served to direct registered manager and provider to take the necessary action within a set timeframe to provide person-centred care and support, with particular regard to ensuring people receive regular baths or showers that reflect their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk was not always managed safely. People did not receive the supervision, monitoring and support required to keep them safe. Risks were not always accurately recorded and did not reflect the level of risk to people.

The enforcement action we took:

Notice of proposal served on provider to impose conditions restricting new admisions and requiring provider to submit weekly reports that measure the safety and effectiveness of the service to ensure people receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate level of managerial oversight of the service.Quality assurance mechanisms were not robust as had not picked up on all of the concerns we found.

The enforcement action we took:

Notice of proposal served on provider to submit weekly reports on quality, safety and effectiveness of service to ensure robust managerial oversight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Insufficient staffing levels deployed to safely and effectively meet people's needs and preferences.

The enforcement action we took:

Notice of proposal served on provider to impose conditions restricting new admisions and requiring them to submit weekly reports of staffing levels and dependency levels to ensure people receive safe care and treatment.