Abbotsford Care Home Limited

Abbotsford Nursing Home - Manchester

Inspection report

8-10 Carlton Road, Whalley Range,
Manchester, M33 4EE
Tel: 0161 226 4430

Date of inspection visit: 13 14 15 May 2015
Date of publication: 20/01/2016

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**

Overall summary

We inspected this service on the 13, 14 and 15 May 2015. The first day of the inspection was unannounced. This meant the service did not know when we would be undertaking an inspection.

The home last had a full inspection in June 2014 where breaches of three regulations were found. A follow up inspection was undertaken in September 2014 which found the home had taken appropriate action to meet the regulations. This planned inspection was brought forward following concerns raised with the Care Quality Commission (CQC) about the safety of people living in the home.

Abbotsford Nursing Home Manchester is a large four storey detached building set in its own grounds. The home provides residential and nursing care for up to 44 people. The home had a diverse cultural mix with approximately half of the people being of Chinese decent and the remaining people being of either Caribbean or British decent.

Summary of findings

On the day of the inspection there were 30 people living in the home. People were accommodated over the four floors and each floor had mixed residential and nursing beds. People who came to live at the home could pick the room they wanted out of those available. All floors were accessible by two staircases at each end of the building and one central lift. All communal areas, including two lounges and a dining room, are situated on the ground floor. The kitchen and laundry facilities are situated in the basement of the building and the treatment and medication room and the hairdressers are on the top floor.

The home had a new manager who will be registering with the Care Quality Commission. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The new manager had been in post for eight days prior to the inspection.

At this inspection we found a number of breaches to the regulations as identified below.

There were times when it was evident staff did not have all the information they needed to support people effectively. For example when one person asked for a drink it took staff approximately 45 minutes to support this person with a drink, we saw different staff discussing different actions that needed to take place before a drink could be offered.

Assessments had not been completed to ascertain if people lacked capacity to make any decisions, including giving their consent for restrictive practice. We looked at the files of people we saw were restricted either by bedrails, lap belts or recliner chairs. We did not see any assessments to support restrictive practice. There were contradictions within care plans and no evidence to support people had been involved with developing them.

Baths and showers were given on a specific day and not based on need. We saw some people had up to five baths or showers a week and others only had one. There was no information within the care plans to support why this differed. When plans of care are generic and not focused on individual assessed need there is a risk people will not get the support they want or need.

We reviewed the records for people who were living with complex health needs. We reviewed records for people who received their nutrition and hydration via a PEG (**Percutaneous endoscopic gastrostomy) tube and records for people who were at a high risk of developing pressure sores.**

We found assessments did not include comprehensive plans of care. We found assessed risk was not reviewed appropriately and where risk was identified steps to reduce associated risks were not implemented. This included the lack of clear nutrition and hydration schedules to be administered via the PEG and pressure relieving aids for people at risk of developing pressure sores. The lack of appropriate assessment followed by effective care planning and review leaves people at risk of receiving care and treatment which is inappropriate or unsafe. **This is a breach of Regulation 9 (1) (3) (a) (b) (c) (d) (f) (of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.**

Throughout the day we observed staff supporting people without engaging in any conversation. We did not see staff giving people choices or acknowledging people's preferences. When staff do not engage in conversation with people when they are supporting them, people are not given the opportunity to be involved in making decisions about their own care. **This is a breach of Regulation 10 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Many people living in the home spoke a different language to most of the care staff. We were told communication cards had been developed to support staff with understanding people's needs. We did not see the communication cards being used on the three days we were at the home. We found when staff could not understand someone they went to get the one staff member who could speak the language of the person they were trying to communicate with. This meant that staff, and most of the people who lived in the home were unable to use verbal communication due to staff's lack of understanding of their preferred language and staff could

Summary of findings

only assume people consented to their care if they offered no resistance. **This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Policies and procedures had been reviewed. However staff had not been given opportunities to read or ask questions on the policies on how to deliver the service. We looked specifically at the detail of four policies and asked staff for their interpretation of them. It was clear from the responses we were given that staff would seek support from the nurse in charge as they did not understand the correct procedure to follow.

We saw a summary for each person's support needs in people's care files. These had not been updated since they had first been completed when people moved into the home. Risks had not always been identified following initial assessment. Therefore risk management plans had not been completed.

We found most people had been assessed as being at a high risk of falls. However when we reviewed relevant documentation this was not supported. There was a risk staff did not have access to the information they needed to keep people safe. We looked at information on how staff would support people in the event of an emergency. We found information was out of date or not accurate. When we reviewed staff personnel files we found some staff had not received training for up to three years. Some staff had not received training, formal support or clinical supervision since they had started in post. **This is a breach of Regulation 12 (1) (2) (a) (b) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

However we did see a home file which included all the relevant certificates for external professional testing of equipment including fire safety equipment, the lift and gas and electrics installations. Emergency numbers were listed for utilities and the stop cock and emergency gas valve were correctly identified. All certificates and checks were in date.

We looked at how medicines were managed within the home and found people were treated with respect during administration and time was taken to support them as required. However when looking at the medicines records we noted that no one had any recorded allergies. Controlled drugs were not managed in line with guidance and one person was administering their own asthma medication without the required risk assessment to ensure they were safe to do so. **This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The home had a safeguarding policy that had been reviewed in April 2015. But none of the staff we spoke with knew of the policies content. It was clear from incidents we witnessed staff were not confident in safeguarding people who lived in the home. We could not find any evidence that staff had received any induction or training in safeguarding since 2010.

We found the previous manager had completed 12 urgent seven day Deprivation of Liberty Safeguards (DoLS) authorisation requests. These are done when action needs to be taken to keep people safe. Certain steps need to be taken during urgent authorisations to ensure the authorisation is completed in line with the Mental Capacity Act 2005. We did not find any records to support these steps had been taken in 11 of the 12 cases. **This is a breach of Regulation 13 (1) (2) (3) (4) (b) (c) (d) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People did not receive the support they needed to ensure they had enough hydration and nutrition. Records kept to support and protect people from malnutrition were not maintained effectively. When care plans identified specific nutrition and hydration schedules for people using a Percutaneous endoscopic gastrostomy (PEG) tube, we found they were not followed. **This is a breach Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The ongoing maintenance and decoration of the building was not based on the needs of the people who lived there and the people who lived there had not been asked for their opinion on the environment in which they lived. The general environment of the home required attention. This included furniture which was worn and chipped, doors, door handles and skirting boards which were also very worn and dirty. Some areas of the building had a malodour and sluice rooms we looked in were not fit for purpose. **This is a breach of Regulation 15 (1) (a) (c) (e) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.**

Summary of findings

A new complaints procedure had been written in March 2015 but the procedure had not been followed to date. It was unclear if the procedure was a new procedure or if it was an updated version of a previous procedure. We were told there were no available records of complaints made or investigations undertaken. If services do not have systems in place for accessible complaints records it is difficult to ascertain if people are complaining and their complaints are being investigated appropriately. **This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

There were no effective systems to monitor the service against the regulations. Systems were not in place to seek the views of people using the service. Records used by staff were not effective in identifying additional support needs and audits were not completed to address areas of concern. Risk assessments were not completed on areas within the home that could hold risk including the kitchen and laundry. Key documentation used to protect people from unnecessary risks was not monitored and quality assured to ensure it was accurate and could be implemented to protect people when needed. **This is a breach of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.**

The Care Quality Commission had received information of concern which highlighted there were not enough staff working at the home to meet the needs of people living there. On the day of the inspection we found this was the case. We found the tool the home used to assess how many staff were required was not reflective of people's needs. We found people were not supported in a timely way and staff were not supported to be competent in their role. **This is a breach regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

We looked at six personnel files to ensure staff had been recruited safely. We found some key information was not available. Information about appropriate checks to ensure suitability including if people were trustworthy and fit and healthy was not available in all the files. **This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it 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.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The service did not have effective contingency plans and personal emergency evacuation plans to support people in the event of an emergency.

There were not enough suitably qualified and trained staff to meet the needs of people living in the home.

Risks to people living in the home had not been appropriately assessed and managed.

The home and furniture was visibly dirty and the home generally required additional maintenance to bring it up to a required standard.

Is the service effective?

Inadequate

The service was not effective.

We found procedures in place to protect people from malnutrition were not effective.

Applications to deprive people of their liberties under the Mental Capacity Act 2005 were not completed in line with the Act and were therefore unlawful.

Staff told us they needed more training and support. We saw it recorded within minutes that they had requested it. It had not been provided.

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

People who lived in the home and relatives we could speak with told us the staff looked after them well.

We saw some staff were respectful to people.

We did not observe staff giving people choices as to how and when they wanted support once support was being provided.

Is the service responsive?

Inadequate

The service was not responsive.

An activity coordinator was in post but only for two hours a day and they did not have the time or the resource to develop the role as they would like.

The provider had not sought the views of people living in the home.

Steps were not taken to support people with understanding their choices.

The home did not keep records of complaints or actions taken to resolve issues.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led

The home did not use audits or monitoring tools to review and improve service provision.

Risk assessments were not completed as required.

Staff were not supported to fulfil their role safely.

When new procedures were introduced staff were not given the opportunity to read and understand them before they were implemented.

Abbotsford Nursing Home - Manchester

Detailed findings

Background to this inspection

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

This inspection took place on the 13, 14 and 15 May 2015. The first day was unannounced. The inspection team included two adult social care inspectors, a pharmacist inspector and a nurse specialist advisor. The pharmacist inspector and nurse specialist advisor were on site only on the 13 May 2015.

A Provider Information Return (PIR) was not requested in time for this inspection as the inspection was bought forward. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Before our inspection, we reviewed the information we held about the home, requested information from Manchester Council, the local safeguarding team, The local Infection Prevention and Control team and the lead safeguarding nurse of the Clinical Commissioning Group (CCG).

During the inspection we spoke with 15 staff including the owner, director, manager, the nurse in charge, senior carers and carers. We spoke with the chef and laundry and domestic staff and the maintenance person. We also spoke with five visiting professionals including a community matron and advanced nurse practitioner from the care home support team and two GPs from the practice providing primary care to the home. We spoke with nine people who lived in the home and two visitors. We observed how staff and people living in the home interacted and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed support provided in the communal areas including the dining room and lounges during lunch and during the medication round. We looked in bedrooms, in the kitchen, laundry and staff offices and in all other areas of the home.

We reviewed 16 people's care files, eight of them in detail to track assessments of support needs through to provision of the support required to reduce risks and keep people healthy. We looked at care monitoring records for personal care, nutrition and hydration records and complex needs records. These included records used to support people who were required to use clinical equipment to meet their basic needs. We looked at how the home monitored and improved service provision, managed medication and undertook risk assessments. We looked at six staff personnel files to ensure staff were recruited safely and received the support they required during employment at the home.

Inadequate

Is the service safe?

Our findings

It was difficult to speak to most people who lived in the home in any detailed way due to language barriers. The home had a dedicated Chinese lounge and English lounge. Each lounge was decorated in a culturally specific way and the television was set to speak in either English or Chinese. This helped people who lived in the home have a sense of belonging and security in their environment. We saw people requesting to be supported to their specific lounge or if able locate themselves within them. One person we did speak with, told us, "Everything is fine, I get a good night's sleep and a good breakfast and that suits me."

On the day of the inspection we completed an observational assessment to ascertain how staff interacted with people who may have had difficulty verbalising their needs. During this assessment we saw one person wait for approximately 45 minutes to receive a drink they requested. This person had a very dry mouth and we could not ascertain why staff took so long to support this person to have a drink. Different staff had different ideas of the person's needs, two staff thought they needed to be hoisted into a different position to receive a drink and one other was unsure. Upon speaking with the nurse in charge following the event the person was safe to receive the drink where they were.

We saw how this person got frustrated prior to receiving a drink. This person's care plan did not include details of why the person could not have a drink where they were, nor did it contain any information on how to support the person's dry mouth. When assessments are not completed accurately or at all and when staff cannot agree on how to provide specific support, people are at risk of not receiving safe care and treatment.

The home had a safeguarding policy that had been reviewed in April 2015. The policy included access to procedures for identifying and reporting safeguarding concerns. Staff we spoke with had not read the policy or had any training on its contents. There were no procedures displayed anywhere in the home to give staff access to information on how to report potential abuse. We could not find any evidence that staff had received any induction or training in safeguarding since 2010. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff and the manager how they managed risk on a day to day basis and were told every morning the manager would speak to the nurse in charge and get an update of any ongoing and new concerns. Information was shared across the nurses during handover. We looked at specific risk information in 16 different files and found risk assessments were in place to support people and keep them safe. This included assessments for moving and handling, nutrition and falls. However most did not have a documented review date and some had not been reviewed for up to six months. We also found that risk management plans on how to reduce associated risks were mostly missing.

We looked in more detail at people's risk of falls and the information held to reduce the risk. We found most people had been assessed as being at a high risk of falls. However work had not been completed to support this. We looked at falls logs which recorded the amount of falls people had and cross referenced this with accident records. We found the falls logs for people were not reflective of accidents reported. For example one person's falls log said they had fallen three times in February 2015 but only two falls were recorded in the accident records. Care plans for people with injuries sustained as a result of a fall did not have body maps or injury or wound management plans in place. Accident records which recorded an injury did not have actions recorded as to how the injury was managed. Accident records and associated care plans did not have appropriate analysis to identify concerns and identify actions to reduce the risk of falls for specific individuals. We spoke with staff about referrals to the falls team and were told no one had been referred. Staff were not clear at what point someone should be referred. When records are not an accurate reflection of events and staff are unsure of procedures to follow to keep people safe there is a risk that people will not receive the support they need. This is a breach regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each file we looked at included a summary assessment of people's needs. This assessment was completed shortly after people became resident in the home and we did not see any that had been updated since. One person's summary stated they had concerns of being given medication covertly. We were told by staff no one received medication covertly yet we found in this person's file an uncompleted best interest decision to administer medication covertly. The decision was not signed or dated

and did not include any names of staff, family or other professionals who had been involved in the decision. There was no risk assessment to reduce and manage the risks associated with this person's concerns or any evidence to suggest the person's feelings had been considered. It was unclear when talking to staff if it was happening or not as different staff told us different things. This is a breach regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records to show us how the home and staff would support people in the event of an emergency. We found some files contained PEEPS (Personal Emergency Evacuation Plans) but none of these had been reviewed since 2013.

We looked at the home's business continuity plan. The plan should show us what the home would do in an event of an emergency, to ensure people living in the home would still receive the support they needed to keep safe. We found the plan was a generic plan that had not been updated to include the specifics of the home. For example the location of the stopcock for the water supply and the location of the emergency gas valve were recorded incorrectly. We found the risk assessments had not been completed to ensure effective risk management strategies could be developed. Staff we spoke with were unclear on what to do in the event of an emergency. If systems and procedures have not been developed and shared to deal with emergencies there is a risk staff would not be equipped to manage an emergency safely. This is a breach regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the maintenance person in the home and found good systems had been developed to monitor specific risks within the home. This included the servicing and testing of equipment used within the home. There was a log book for maintenance work that staff would record in when work was needed. The maintenance person would work through the book daily until tasks were completed. They would also walk around the building daily to complete a security check ensuring that external doors and lights were in good order. There was a home file which included all the relevant certificates for external professional testing of equipment including fire safety equipment, the lift and gas and electrics installations. All certificates and checks were in date.

We saw the maintenance person completed daily, weekly and monthly checks on different aspects of home safety including testing of bedrails, profile beds and water temperatures. Fire doors were checked monthly and we noted from the records some fire doors were identified as not closing properly in April 2015. It was not clear from the records what action had been taken to rectify this. On the day of the inspection we noted a number of fire doors some of which had already been identified did not fit snugly into their frame upon closing. We discussed with the manager who assured us action would be taken.

We spoke with the manager and home director about how staffing levels were assessed to ensure there were enough suitably qualified and experienced staff to meet the needs of people living in the home. We were told a dependency tool was used which was taken from the assessments within the care plans. We reviewed the tool used and looked in detail at three of the dependency assessments and in general at all of them. The assessment scored zero for no support needs and increased numerically dependant on need.

We found a number of inconsistencies within the dependency tool used. For example one person we looked at in detail scored zero for eyesight (good without glasses/ lenses). Upon looking at their care file we found they were blind in one eye and wore glasses. Another scored two for personal care needs (needs support of one person) in their care plan it stated they required two people for all personal care needs. Another scored zero for pressure sore risk, yet within their care file they had a high risk water low assessment and high pressure sore risk on their sacrum and heels. The language barriers caused huge problems in the home. We saw at times three to four staff talking to one individual trying to ascertain their needs. Yet on the dependency assessment 18 out of the 30 people living in the home scored zero for communication. We discussed this with the director who acknowledged they had completed the assessment by talking with the nurse in charge on the day they had completed the assessment, rather than reviewing the information written within people's care files.

The Care Quality Commission had received information of concern which highlighted there were not enough staff working at the home to meet the needs of people living there. On the day of the inspection we found that there were not enough suitably qualified and trained staff to

meet the needs of people living in the home. We saw people being moved to the dining room 30 minutes before lunch was served. There were people sat in the dining room waiting to go back to the lounge nearly two hours after lunch had finished. We saw staff still needed to support a number of people with their personal hygiene needs while other people were starting their lunch. When we looked at bath records we saw that one staff member had supported people with their personal care needs when their care plans indicated two staff were needed to provide effective support.

As detailed above the assessment used for ensuring there was enough suitably qualified and experienced staff to meet the needs of people living in the home was not reflective of people's needs. On the day of the inspection we observed there were not enough suitably qualified and trained staff to meet the needs of people in an effective and timely way. When assessments used to determine the numbers of staff required to meet people's needs are not completed correctly and staff are not suitably trained and competent there is a risk that suitable staff will not be in place to meet people's needs and people will be put at risk. This is a breach regulation 18 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at six personnel files in detail for different staff working at the home. We found a number of issues associated with safe recruitment. This included staff working without any appropriate criminal records checks such as POVA (Protection of Vulnerable Adults) or DBS (Disclosure and Barring Service) information on file. We were assured that this information for recent employees was in place but historically there remained some ambiguity. Some references were not from the person's previous employer. We identified one file where a risk assessment was required for information declared within an application form but one had not been undertaken that could be found.

The lack of appropriate checks and assessments meant that some staff that were in employment may potentially not be fit for their role or legally contracted to fulfil the responsibilities of that role. A lack of information to determine if people were suitable for employment is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC had been contacted prior to the inspection by the Clinical Commissioning Group and the Local Authority who identified concerns with how the home was managing medicines. On the first day of the inspection we took a dedicated pharmacist inspector to review this. We found the medicines trolley was stored safely and locked when not in use. When observing the medicines round we saw the Medicines Administration Record (MAR) was signed immediately after medicine was administered and staff treated people living in the home respectfully during this time.

We looked at 10 MAR charts and reviewed the detail in five of them on the morning medication round. We found medicine recorded on the chart was accurate to what had been administered from blister packs (Storage pack for medicine). When prescriptions had changed following a time in hospital, records were amended accordingly and dated the day of discharge ensuring continuity of the prescription. There were no gaps in the administration records and we found an updated signatories list in the front of the medicines file.

During the teatime medicine round we looked at 15 MAR charts and looked in detail at five. We saw people who were on medicines required up to seven times a day were given them at the required time to ensure their condition was managed. We reviewed records of the nurse monitoring people with diabetes and found records were in place and people were treated and administered medicines as required.

However we did identify some concerns with how medicines were managed at the home. One person was self-administering their medicine for treatment of their asthma condition without a risk assessment. We discussed this with the nursing team who acknowledged this was required.

Some people living in the home had medicines prescribed for as needed. This is commonly Paracetamol but can also be other medicines. The home did not have a protocol in place for how to manage these types of medicines nor were there individual care plans to support their administration. We would have expected to find both a protocol and details of how individuals' used the medicine in place. If the medicine was prescribed for someone who could not verbalise when they needed the medicine staff needed more information to ensure the medicine was used as required by the individual. The manager assured us they would be undertaking an audit of medicine management shortly and all required action would be completed.

Inadequate

Is the service safe?

When looking at all the medicines records we noted that no one had any recorded allergies. We discussed this with the manager who assured us this would be looked into as a matter of urgency. We looked at how the home managed controlled drugs. Controlled Drugs (CDs) are medicines that could potentially cause more serious harm if not managed appropriately. We found how the home stored CDs was not in line with the The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (SI 2013/373)). The CDs at the home were stored in a strong safe with a keypad inside of a wooden cabinet. Regulation dictate CDs should be stored in a specific way to ensure their safety. We also found the Controlled Drugs register which should show what CDs are in the safe was not accurate. There was a higher quantity of one CD in the safe than was on the register. This is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previous CQC inspections had identified ongoing issues with the condition of the building and some of its services including the sluice rooms. Sluice rooms are used to manage clinical waste. At our last inspection assurances were given this work would be completed by December 2014. The condition of the building had also been a concern for the local authority and there was an expectation work would be completed by February 2015. During this inspection it was evident that still further work was required to bring the building and services up to a suitable standard.

We found many commodes used in people's bedrooms were chipped and rusty. Many beds we looked at were old divan style beds, were heavily stained and did not have mattress covers. Bedding and towels were also very old and frayed. We looked at furniture within the home and found chairs, tables and other fixed furniture were in a bad state of repair including the over bed tables which were used by some people to eat their meals off. We looked at the general cleanliness and state of repair of the building and saw that the door handles we looked at were visibly dirty there was an unpleasant smell in some parts of the home and doors and skirting boards specifically to the ground floor toilet area were very worn with paint and varnish chipped and worn in many places revealing bare wood. When furniture and fixtures are in a poor state of repair there is a risk of bacteria forming which increases the risk of potential infections.

The sluice rooms we looked in were not fit for purpose. None of the sluice rooms had Personal Protective Equipment (PPE) in them although it was available in many of the hallways. Most did not have appropriate clinical waste bins. The sluice rooms were generally in bad states of repair and where work had been done for Infection Prevention Control (IPC) this had not been effective. For example ply wood had been used to seal basins but the wood was not sealed to either the basin or the floor, it had not been painted so was absorbing liquid. We found this to be in breach

of Regulation 15 (1) (a) (e) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. We spoke with the manager shortly after the inspection and were told they had completed an initial environmental audit and submitted orders for some replacement goods which had been approved.

Inadequate

Is the service effective?

Our findings

It was difficult to speak with people living in the home about whether they thought there was enough suitably qualified staff to meet their needs. One person told us "I push my buzzer very rarely but when I do staff seem to be here quite quickly."

We looked at staff supervision records kept by the previous manager. We saw records identified nine staff had received at least one supervision, up to the time of the inspection in May 2015. We asked five staff about the supervision they had received. It was unclear if two of the staff we spoke with knew what supervision was. This was because one staff member told us they had received supervision but there was no record of it and two others told us they had not, yet it was recorded that they had received it. We reviewed nine supervision records and noted that in six of them staff had identified with the previous manager they felt under pressure and there was not enough suitable staff. Five had also requested additional training. Supervision records completed by the nurse clearly all showed staff raising concerns about the level of care they felt they were able to give indicating that there was not enough time for them to do the job as they would hope to be able to.

We spoke with two nurses and both told us they had not received any clinical supervision or support since they had been in post. One told us, "We only have one registered nurse on shift at any one time so it can be emotionally and physically challenging. Management support has been poor in the past and I felt like I was just left to get on with it." All staff had requested additional training but nurses had specifically asked for training for helping support people in the home who had complex needs. This training had not been provided by the time of our inspection. A specialist nurse was on the CQC team of inspectors and they raised concerns about this lack of training. The specialist nurse was able to offer some immediate support to nurses and information for this support was displayed in the rooms of people with complex needs. When staff do not receive the support they need to effectively complete their role it is a breach of Regulation 12 (2) (c) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at records the home held for consent. We saw a generic form was used for everyone who lived in the home. The form asked people when they first moved into the home to give their consent for assistance with seven core daily tasks which included bathing/showering and eating and drinking. The form was to be signed by the person themselves or a representative. None of the forms we looked at were clear as to whether the person or representative had signed in agreement. The forms also included consent for the person's photograph to be taken. A paragraph on the bottom of the form clearly identified that staff should always seek consent to support people with their personal care and if this could not be given then a best interest decision should be undertaken with the family and other professionals. The form did not include consent for the home to manage people's medication nor did it highlight specific consent before any intervention other than personal care. All the forms we saw had been signed.

We looked at the files of people who we were told did not have the capacity to make their own decisions. Only in one of these files was there a record of a best interest meeting. There were no capacity assessments in any of the 12 files we looked at. On the day of the inspection we completed a SOFI which helped us identify how people's consent was gained. We also looked at general interactions between staff and the people who lived in the home. Mostly we saw staff telling people what they needed them to do in order for the staff to move them or support them with their food. We also saw on at least four occasions when staff did not communicate with people as they started to support them. For example we saw one person who was supported to eat their lunch. They were asleep in the chair and the first they knew about their lunch being ready was when a staff member held a spoon to their mouth.

Many people who lived in the home spoke a different language to most of the care staff. We were told communication cards had been developed to support staff in understanding what people needed. We did not see the communication cards used on the three days we were at the home. When we discussed the cards with the manager we were told they required further work as they were too small. When staff could not understand someone they went to get the one staff member who could speak the language of the person they were trying to communicate with. This meant that staff and most people who lived in the home communicated in a non-verbal way. Staff assumed people consented to the support offered if they did not put up any

resistance. When care and treatment is provided without appropriate consent it is a breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We were told 12 people had an active Deprivation of Liberty Safeguards (DoLS) in place. A DoLS is used when people do not have capacity to either give consent to something or may be refusing something or trying to do something which as a consequence may increase risks to their health and wellbeing.

The Care Quality Commission has a statutory duty to monitor the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). The aim is to make sure that people in care homes, hospitals and supported living who lack the capacity to make decisions for themselves are looked after in a way that does not inappropriately restrict their choices.

We looked at the 12 DoLs the home told us were in place. We found only one of them had followed the procedure as identified within the MCA 2005. Assessments had not been completed to ascertain if people lacked capacity to make any decisions including giving their consent for restrictive practice. Restrictive practice includes the use of bedrails to stop someone falling or getting out of bed, lap belts on wheelchairs to stop people slipping or getting out of wheelchairs and the use of recliner chairs to stop people getting up. Assessments for restrictive practice had not been completed in any of the files we looked at where we saw restrictive practice was taking place. We were told the people being restricted lacked capacity yet their care plans did not support this. There were contradictions within care plans and no evidence to support people had been involved with developing them. This is a breach of Regulation 9 (1) (3) (a) (c) (d) (f) (4) (5) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked to see if there were any records to support the DoLS submissions. We found the previous manager had completed 12 urgent authorisations but there was only some records to support one of them was required. There was no action taken during the seven days these were in place. This included no attempts that could be seen of contacting other professionals, people's family or appropriate advocacy services. We were assured after the inspection that four applications had been made to the authority but these had not been progressed to date. All staff at the home were under the impression the applications were granted and people were being restricted. We found a lack of accurate and complete information to support the DoLs application is a breach of Regulation 13 (5) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at available information to ensure people's nutrition and hydration needs were met. We spoke with the chef about records kept about what people had eaten and were told the food and fluid charts were all that was used. We asked to see information for people with special diets or with specific likes and dislikes. There was only one piece of information about someone who received a soft diet. We were told there were two choices every day. As the people who used the service had very different dietary likes and dislikes we found that in essence there was one choice for each person on most days. No work had been done to ascertain what particular dishes people liked but the chef had taken time to research Caribbean food to try and ensure the food was to their liking.

We reviewed five files and saw information was conflicting. For example in one file we saw the person had been weighed monthly and the information had been used to complete a monthly MUST (Malnutrition Universal Screening Tool). The tool had stated no change yet the person had lost 8Kgs in the last two months. The nutrition assessment had not been updated since March 2015 and the care plan evaluation, used monthly for reviews, stated the care plan was still relevant and the person was stable. We raised this with the manager and a dietician referral was made the same day. We also raised a safeguarding alert with the local authority to ensure this person was kept safe.

We observed the lunch time routine and saw how staff supported people with their meals. We found that some people who lived in the home would have benefited from additional support to eat their meals. We talked with the chef (who was also a senior carer) about the use of adaptive cutlery and plate guards. We found that people would benefit from the use of adaptive cutlery and were told the chef would discuss it with the manager.

Some people who were considered a risk of malnutrition had their food and fluid intake recorded on additional charts to monitor they were eating and drinking enough. We reviewed the charts for four people and found they

were not consistently or correctly completed. Some had not been completed every day and when they were completed it was difficult to ascertain what and how much had been eaten. For example one said porridge had been given at breakfast but it did not say how much was eaten, another said, 'pudding eaten all ok' but did not identify what food had been eaten or how much all was. We spoke with the new manager about our concerns and we were told extra care monitoring including food and fluid charts would be discussed at the team meeting.

Two people who lived at the home received their nutrition and hydration through a Percutaneous endoscopic gastrostomy (PEG) tube. This tube passes food and fluids directly into a person's stomach. One of these people did not have an up to date care plan to support their PEG routine. The other had a couple of lines on the food and fluid chart to say how much and when food and water should be given. We looked in detail at the last two weeks and found that the two lined care plan had not been followed correctly on any of the 14 days. We raised a safeguarding alert with the local authority to ensure this person was kept safe. We found procedures in place to ensure people were in receipt of enough nutrition and hydration were ineffective and in breach Regulation 14 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

On the day of the inspection we saw visiting professionals from the local GP practice and from the local nursing home team. When reviewing people's care files we saw records were kept of visiting professionals included the district nursing team and chiropodists.

We were told most people who lived in the home were living with some form of dementia. In recent years lots of work has been undertaken to support how the design of an environment people live in can improve their well-being. This is true of most people but is specifically beneficial for people who live with dementia. Colours, signage and items that are tactile can benefit and stimulate people's minds.

Abbotsford nursing home had predominantly white walls, with little or no pictures. Doors were all white and there was no indication what was behind doors other than some doors had name plates on them indicating it was their bedroom. The home was very large and there was no signage to say where certain rooms were or in what direction you could find a toilet. We were told by staff and the management that no consideration had been given to the people who lived in the home when decisions about decoration had been agreed.

The activity coordinator had some good ideas about decorating a particular hallway with memories from the past but said a budget was needed. There was no available meaningful activity to keep people stimulated and involved with their environment including the availability of items which have been shown to be interesting to people living with dementia. The provider had not considered the needs of the people who lived in the home when they had purchased items to keep people engaged with their environment.

The ongoing maintenance and decoration of the building was not based on the needs of the people who lived there. This is a breach of Regulation 15 (1) (c) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We saw there was a disabled entrance to the building with ramped access for use by people using wheelchairs.

Requires improvement

Is the service caring?

Our findings

We spoke with some people who lived in the home and their relatives about how they were treated by the staff who worked at the home. Everyone we spoke with was positive about the staff. One person who had lived at the home for a number of years said, "The staff are lovely, I can do a lot for myself but the staff always ask if there is anything they can do for me."

The home had two lounges one decorated in a Chinese style and the other in a more European style. We were told by staff this was to meet the needs of the two diverse cultures of the people who lived in the home. One was named the Chinese lounge and the other named the English lounge. The TV in each lounge was set in the language of the lounge style. This enabled people to enjoy news and current affairs in a language they understood.

At the time of our inspection more than 50% of the 30 people living in the home were Chinese speaking. On the days of the inspection there was only one staff member who was able to speak the language. Communication cards which had been developed were not used to communicate with people over any of the days of our inspection. We noted staff asking the staff member who spoke Chinese to translate for them. This meant this staff member was often called off the task they were completing. Staff could not deliver care to some people, without the second person to translate. This consequently led to tasks which could be performed by one person requiring two..

We observed how staff interacted with people who lived in the home. Generally staff appeared to be concerned about people's welfare. When people got up to move who were not too steady on their feet we saw a staff member get up to follow them in case they needed assistance. However it was not clear if staff had all the information they required to deliver personalised support to people in the home.

We completed a SOFI (Short Observational Framework for Inspection) to help us understand if people had their needs met who could not communicate well with the staff supporting them. We found that one person's needs were not known by some staff who were trying to support them. Some staff believed the person needed to be moved with the aid of a hoist to a different position in order for them to have a drink. It was clear this person did not want to be moved in this way as they became agitated. We asked the staff member if the person had any swallowing difficulties and if they were supported by the Speech and Language Team (SaLT). The staff member was unsure but was insistent they needed to be moved before they could have a drink. We asked the nurse in charge the same questions and were told no. We asked if the person could have a drink where they were and was told yes. The person got a drink nearly 45 minutes after requesting it.

We found there was a breach of Regulation 9 (1) (3) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at eight care plans to see how people were involved in decisions around their care. We did not see any documentation to say people were involved with developing how they received care. Some paperwork had been completed which identified people's choices and preferences but this information had not been used to inform people's care plans. We saw bath records which recorded when people had a bath or a shower. These records showed people had access to a bath or shower on a certain day and this was not based on their preference or need. We also noted that some records showed people had received the support of one staff member when their care plan indicated they required the support of two staff.

We observed how people were asked for their views throughout the day and how staff gave people who lived in the home choices upon which they could make decisions. On the first day of the inspection we saw two people being supported to move with the use of a hoist. On both occasions people were not asked if they wanted to be moved. Staff told one person, "We are going to move you to the dining room for lunch now." There was no pause to wait for a response from the person and what followed was instructions to the person on what and how to move so staff could position the sling of the hoist appropriately. One person did not like how they were being moved and became upset. This person was reassured by staff, but staff did not stop what they were doing and continued moving the person irrespective of their objections.

Whilst undertaking the SOFI (Short Observational Framework for Inspection) we observed one person being supported with their lunch. The staff did not communicate with the person about what they were doing or what they were being given to eat. We saw the staff member hold a spoon to the person's lips and push gently to encourage

Requires improvement

Is the service caring?

the person to open their mouth. This continued until the staff member was spoken to by another member of staff when they got up and went to do something else. They did not ask the permission of the person they were supporting with their meal nor inform them of where they were going and when they would be back. When they returned approximately five minutes later they again pushed the spoon gently into the person's mouth to encourage them to open it. The person who was receiving the support with their lunch was drifting in and out of sleep.

When staff do not engage in conversation with people when they are supporting them, people are not given the opportunity to be involved with their own care. This could include people expressing choice, including refusal to care and treatment at specific times or in specific ways. When people are not supported to be involved with their own care it is a breach of Regulation 10 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the home were well dressed, clean in their appearance and nicely groomed. We saw staff knocked on bedroom doors before they entered and we saw most people's rooms were decorated with personal possessions and photographs. There was a hairdresser who visited the home once a week and staff told us who liked to have their hair done.

The relatives we spoke with confirmed that they were able to visit the home whenever they wanted and were welcomed by the staff.

Inadequate

Is the service responsive?

Our findings

We spoke with people about how they spent their days. Many people were not clear what we were asking but one person told us, "I like to feed the birds and squirrels, the staff have put a bird feeder outside my room so I can see the birds come to eat the food." Another told us, "There is not much to do, and there is one person around some mornings who does things with us but that is it."

On the day of the inspection we spoke with the activity co-ordinater who confirmed they were at the home for two hours each day. The activity coordinator was planting flowers with one person in the garden. They were planning to develop an area for reflection which included a bench within a calm planted area. Family members or other people living in the home could use the bench to reflect when someone passed away. The activity coordinator told us they had some great ideas for how they would like to improve the quality of life for the people who lived in the home. However they said they did not have a budget to make these improvements and needed support to implement them. Some of their suggestions would address some of the areas where breaches had been found in Regulation 15. We saw on the notice boards activities which had been arranged. The themes were specific to the seasons and on the day of the inspection the focus was on spring and new growth. Activities included external visiting entertainers to the home.

In all of the care plans we reviewed we noted plans were developed with a focus on the task rather than on the individual. Plans were developed around activities of daily living including eating, mobilising and personal care. Plans were very generic and did not include any information from the individual perspective. There was no evidence within the plans that people had been involved with developing or identifying their own care and support needs.

We reviewed the personal care needs of seven people who lived in the home and saw no individualised plans for how their needs were to be met. We were shown a bath chart which included bath details for everyone who lived in the home. Baths and showers were given on a specific day and not based on need. We saw some people had up to five baths or showers a week and others only had one. There was no information within the care plans to support why this differed. We also noted in minutes of a team meeting in May 2014 that this should have stopped as the previous manager identified the approach was not person centred. When plans of care are generic and not focused on individual assessed need there is a risk people will not get the support they want or need. This is a breach of Regulation 9 (1) of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We looked at the records for people who were living with complex health needs. We reviewed the Waterlow assessments of four people. The assessments are used to determine the risk of pressure sores and provide guidance on how the reduce the risk. When these are completed at initial assessment the score dictates the time for the assessment to be reviewed. Reviews should be as much as weekly if the assessment showed a person to be at high risk of pressure sores. We saw two assessments where the score was 20 or above and they along with all Waterlow assessments we looked at were reviewed only monthly. One person identified as high risk on the Waterlow had identified pressure risk areas. There was no care plan or observations in place to monitor the risk areas. We saw this person sitting in a recliner chair without using any pressure reliving cushions or aids. The lack of appropriate assessment followed by effective care planning and review leaves people at risk of receiving care and treatment that is inappropriate or unsafe. This is a breach of Regulation 9 (1) (3) (b) of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We reviewed one person's care file that we had been told required additional support when they became anxious. We saw within the file a risk management plan in place to reduce the risk of the person becoming anxious. The strategy identified the need for staff to be clear and specific with instruction and to explain procedures and interventions before they were undertaken. Behaviour charts were in place for 15 minute observations. We found a clip board with a number of completed charts on, in an empty bedroom. The charts on this clipboard were not an accurate reflection of the day's activity on the two days of the inspection as two incidents we witnessed were not recorded. The charts had not been completed accurately and were a duplicate record for one of the inspection days as a chart was also found in the office.

Charts were out of sequence and did not appear to be used to evaluate, review and manage the risk. We did not see anyone follow the risk reduction strategy when they spoke with this person. When observations required to support

Inadequate

Is the service responsive?

people whose needs maybe higher are not accurately completed or are duplicated it is difficult to ascertain if higher support needs continue because they are not being managed appropriately. Records also indicated this person refused support with personal care needs and nothing had been done to date. When information is not monitored, assessed and reviewed to improve services for people we cannot ensure this person received the support they needed. When records are not accurate or maintained securely it is a breach of Regulation 17 (1) (2) (a) (b) (c) of the health and social Care Act 2008 (Regulated Activities) 2014.

We reviewed available policy and procedures and noted a new complaints procedure had been written in March 2015. We asked the manager if there were any records of complaints and associated investigations. We were told they were none on record that could be found. If services do not have systems in place for accessible complaints records it is difficult to ascertain if people are complaining and their complaints are being investigated appropriately. For a system and associated records not to be available is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw records indicated people could make some choices about what to wear and how to spend their day but we did not see any evidence to support this. We did however see some staff asking for acknowledgment that they were meeting people's needs and adhering to their requests. This was done by way of asking 'Is this ok' and 'is that better.'

Inadequate

Is the service well-led?

Our findings

The manager at the time of the inspection had been in post for 5 days. The previous manager had left but was yet to deregister with the Commission.

We spoke with visiting professionals and staff at the home about the transitional period between the old and the new manager. Staff were positive that the new manager would address concerns that had previously been left undealt with. There had not been any team meetings for some time and staff support and supervision had been limited. Staff and the people who lived in the home had previously not been involved with how the home was managed but the new manager was keen to get everyone involved to move the home forward.

We observed literature around the home identifying the homes philosophy and aims and objectives. We reviewed the service user guide available in reception for people to take away and read. Upon reviewing these documents it was clear they had not been updated for some time. Pictures were of how the home used to look and not how it looked now. Information within the service user guide was inaccurate in that it stated the CQC were still inspecting against the essential standards of quality and safety which had not been used since April 2014.

We discussed with the new manager and the assistant director about how they saw the home and it was acknowledged there was a lot of work to do. As soon as the new manager stared in post they had met with the lead nurse daily to discuss any risks or concerns that required addressing. The lead nurse said they felt more support would be available to them as the new manager settled in.

During the first day of the inspection we were informed a staff member was pregnant and they were potentially left in a position that was not safe for them. We discussed this with the manager who was not aware this person was pregnant. As the day progressed we were told of a second member of staff who was also pregnant. None of the staff had been supported to complete their role whilst pregnant. A risk assessment had not been completed and they were unsure what part of their role was and was not safe for them to continue. Many of the tasks undertaken by carers can include some form of manual lifting, there are also times when carers may have to deal with unpredictable situations that could become aggressive. These situations should be assessed to ensure pregnant staff are safe to continue with this part of their role. Staff told us they had informed the previous manager they were pregnant. When staff do not receive the support they require to safely fulfil their role it is a breach of Regulation 19 (1) (C) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.When we discussed this with the new manager they were not aware the staff members were pregnant and assured us they would complete a risk assessment as a matter of urgency.

On the day of the inspection we asked for the staff handbook to be forwarded to us. We received this and reviewed the content. There was no information around safeguarding and whistle blowing. Whistle blowing procedures are important for staff to have access to, in case they witness other staff members conducting themselves in a way that is detrimental to the health and wellbeing of people living in the home.

We reviewed available policy and procedures and found that most of these had been reviewed in March 2015. When we spoke with staff about the updated policies it was clear they were not aware of them. Staff had not been given opportunities to read the new policies or ask any questions about their implementation. We looked specifically at policies for medication, accidents and incidents and health and safety. When we asked staff how they would deal with events under these policies they all told us they would refer the information to the nurse in charge. Policies and procedures are developed and reviewed to ensure they are in line with current best practice guidelines and changes within the law. If these changes are not disseminated to all staff including the nurse in charge there is a risk that staff are undertaking duties based on their interpretation of events and the right thing to do rather than on agreed policies and procedures. The nurses made decisions based on their own competence and knowledge of situations rather than on the written policy. This can leave both people who live in the home and staff at risk of receiving and delivering inappropriate care and treatment. This is a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager was not aware of any systems and audits in place to monitor and improve practice.

We were told the care plans had not been audited for some time. This was clear when we reviewed files as information held within them was not consistent. For example risk

Inadequate

Is the service well-led?

assessments identifying people as a moderate risk of falls had not been reviewed for 12 months. Documents and body maps which showed no skin breaks were contradicted by visiting professionals who were managing wounds. Assessments showed reduced risks in behaviour whilst other care plans for cognition stated the person remained agitated when care was being delivered. Falls risk assessments identified no falls within the last three years and accident reports said the person had fallen three times in two months. We found contradicting and confusing information across most care plans we looked at.

We reviewed the records used to monitor specific support needs. This included observations charts, food and fluid chart, turning charts and bath charts. The records were not completed in a format that could be used to monitor changes in the support required. For example food and fluid charts did not identify the food eaten or the amount eaten. This would not allow staff to identify if certain foods were eaten more of, or if the person being monitored was eating enough of a specific type of food. Bath charts did not show if someone had their hair washed, their nails cut or record if any observations were made of the person's physical health. This meant the information could not be used to support any additional needs including if the person had any injuries.

We looked at the last health and safety audit completed in 2014. The audit was not completed correctly, where it was completed it was not scored or risk assessed and no action plan had been developed to meet the areas that required attention. We looked at the last infection control audit completed in 2014. The audit identified a number of issues that were still evident on the day of our inspection. It appeared the issues had been signed off as completed as a one off action without any ongoing monitoring. Issues included black bags in clinical waste bins, dirty toilet brushes, dirty mattresses and missing mattress covers. We noted on the day of the inspection that some clinical waste bins had black bags in them, some mattress were dirty and some did not have mattress covers.

When walking around the building we noted there were fire evacuation notices on each floor. But these were all different. The laundry and kitchen staff told us they were not aware of any risk assessments for their area. We noted that a lot of the rooms had loose wiring and cabling which needed to be secured. The maintenance man told us they had purchased trunking to secure this. A maintenance audit and risk assessment had not been formally undertaken so these potential risks were not being formally monitored and assessed.

On the day of the inspection an ambulance was called as one person had fallen very ill. When the ambulance arrived they were told the person was on a DNAR (Do Not Attempt Resuscitation). We reviewed this documentation and found there to be some discrepancies within it. We informed the home and the information was retracted. We spoke with the GP service supporting the home and discussed the issues. We were given assurances the forms would be correctly completed and the additional supporting information would be made available within the care plans.

We discussed the systems the home had in place to monitor quality and the safety of service provision. It was clear many systems had not been implemented for some time at the home. Monthly and quarterly audits had not been completed on care plans, medication, infection control and health and safety. Staff had not received appropriate clinical supervision to support them when working with people with nursing needs and staff or people who lived in the home had not been asked their thoughts on the service and how it was provided.

When services do not have effective systems to monitor their service against the regulations, they cannot effectively adapt the service to the changing needs of the people who live there. When records used are not effective in identifying additional support needs there is a risk people will not get additional support when it is required. When audits are not completed correctly or information within them is not used effectively there is a risk that the same issues will be picked up and risks will increase. When risk assessments are not completed on areas within the home that could hold risk including the kitchen and laundry there is a risk staff and people living in the home are not protected from those risks. When key documentation used to protect people from unnecessary risks are not monitored and quality assured there is a risk that when they are most needed they cannot be used to protect people who need them most.

We found there were multiple breaches of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked how the home worked with people who lived there to ensure they were happy with the service they

Inadequate

Is the service well-led?

received. We were told the new manager would set up resident and relatives meetings to gather their feedback and thoughts on service provision. We were shown meeting minutes of the last resident meeting which had been held in May 2014. Some people had asked for changes to the breakfast routine and had requested an earlier drink in the morning. We could not find any evidence that this had happened. However when we spoke with staff we were told people could have a drink when they wanted and we observed this happening.

A resident questionnaire had not been completed for some time but again we were assured the new manager would implement these. When systems are not in place to receive feedback form people who live in the home there is no way to gauge if people are happy with the service they receive. If records are not kept of all feedback and any associated actions there is no way of establishing if a service is improving. To not actively seek feedback and act on it is a breach of Regulation 17 (1) (2) (f) of the Health and social Care Act 2008 (Regulated Activities) regulations 2014.

Staff we spoke with who were working to support people in the home were committed to improve the service they delivered and were supportive of the new manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People were not involved with their own care and treatment** **Regulation 10 (1) (2) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Information including policies and procedures were not shared with staff in a way for them to be confident with their implementation.** **Regulation 12 (1)** **The registered person did not have effective systems to protect people from assessed risk.** **We found assessed risks were not managed appropriately and identified action to reduce risks was not undertaken.** **Regulation 12 (1) (2) (b)** **Staff were not supported to effectively carry out their role.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 12 (1) (2) (c) Procedures followed for the safe recording and management of medicines were inadequate. Regulation 12 (1) (2) (g) The registered person had not taken appropriate steps to protect people in the event of an emergency. Regulation 12 (1) (2) (i)
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's support was not assessed in line with their specific needs. Regulation 9 (1) Assessments had not been completed or were contradictory with respect to the use of restrictive practice. Regulation 9 (1) (3) (a) (c) (d) (f) (5) Staff were not assessing people's needs effectively; people's needs were not always met. Regulation 9 (1) (3) (a) (b) (c) (d)

This section is primarily information for the provider

Action we have told the provider to take

There was a lack of appropriate assessment followed by effective care planning.

Regulation 9 (1) (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Care and treatment was provided without required consent.** **Regulation 11**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People were not safe because staff did not understand what constituted abuse.** **Regulation 13 (1) (2) (3) (4) (b) (c) (d)** **There was a lack of accurate and complete information to support the application and implementation of Deprivation of Liberty Safeguards application** **Regulation 13 (5)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Procedures in place to ensure people were in receipt of enough nutrition and hydration were ineffective** **Regulation 14 (1) (2) (a) (b) (4) (a) (b) (c) (d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.** **The building and environment did not meet the needs of the people who lived in the home.** **Regulation 15 (1) (c)** **The home was not maintained effectively nor was it clean; sluice rooms we looked in were not fit for purpose.** **Regulation 15 (1) (a) (c) (e) (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 of the Health and Social Care Act 2008 9Regulated Activities) Regulation 2014.** **Procedures for managing, investigating, recording and responding to complaints were not followed.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the health and social Care Act 2008 (Regulated Activities) 2014. Records were not accurate of events and records were not stored securely Regulation 17 (1) (2) (c) The service did not actively seek and act upon feedback. Regulation 17 (1) (2) (f) The service did not have effective systems to monitor the service. Risk assessments were not completed. Key documentation used to protect people from unnecessary risks was not monitored and quality assured. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 There were not enough suitably qualified and trained staff to meet the needs of people living in the home. Regulation 18 (1)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of required information to determine if people were suitable for employment. Regulation 19 (1) (C) (2) (3)-