South West Care Homes Limited

Ashfield

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

An unannounced inspection took place on 12 and 17 June 2015. It was carried out by two inspectors. Ashfield provides accommodation and 24 hour care for up to 25 people. There were 19 people living at the home on the first day of our inspection. On the second day, a further two people were temporarily staying at the home to provide respite for their carers.

A registered manager was not in post as they had resigned in February 2015. 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'. There was a new manager who had just started working at the home and was in the process of registering as a manager with CQC. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others.

Summary of findings

At the time of the inspection, three applications had been made to the local authority in relation to people who lived at the service; the DoLS team had not been updated regarding a change to one person's circumstances which would have escalated their case to be reviewed. The new manager told us they would be reviewing people living at the home to see if further applications needed to be made.

Improvements were needed to manage some risks to some people's safety and well-being. There were not always sufficient numbers of staff on duty in communal areas to meet people's needs at some mealtimes. People's medicines were not always managed safely. Improvements were needed to reduce environmental and infection control risks.

Improvements were needed to ensure staff received regular supervisions and appraisals. Some staff needed further support to enhance their practice. The layout of some communal areas could be improved to enable people to have more space to move around. It was not clear if care plans were written in conjunction with individuals and their representatives.

People's individual care needs were assessed but reviews had not recently taken place to ensure people's care needs were met and people were happy with their care. Improvements were needed to record, manage and respond to complaints.

There were quality assurance systems in place to monitor, identify and manage the quality of the service but there were areas that needed to be improved to make them more effective to ensure people experienced a high standard of care. CQC were not always informed of notifiable events that had taken place in the home.

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

However, there were also aspects of care that supported people's safety and well-being. Staff who worked at the service had generally undergone a robust recruitment process and knew how to recognise and report allegations of abuse.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered. Staff knew their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported to access healthcare services to meet their needs. People's nutritional needs were monitored.

People were treated with dignity and with kindness and respect. Staff understood people's individuality and communicated effectively with them about their support. People were asked about their preferences and activities were arranged in the home.

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?

There were aspects of the service, which were not safe.

Improvements were needed to manage some risks to some people's safety and well-being.

There were not always sufficient numbers of staff in communal areas to meet people's needs at some mealtimes.

People's medicines were not always managed safely.

Improvements were needed to reduce environmental and infection control risks.

Staff who worked at the service had generally undergone a robust recruitment process.

Staff knew how to recognise and report allegations of abuse.

Requires improvement

Is the service effective?

There were aspects of the service, which were not effective.

Staff had not received regular supervisions and appraisals, although this was being addressed. Some staff members' practice was not based on person centred practice.

The quality of information in people's care plans needed to improve.

The layout of some communal areas impacted on the space for people to move around.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered. Staff knew their responsibility under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported to access healthcare services to meet their needs.

Requires improvement

Is the service caring?

The service was caring.

People were treated with dignity and with kindness and respect.

Staff understood people's individuality and communicated effectively with them about their support.

Good

Is the service responsive?

There were aspects of the service, which were not responsive.

Requires improvement

Summary of findings

People's individual care needs were assessed but reviews had not recently taken place to ensure people's care needs were met and that people were happy with their care.

Improvements were needed to record, manage and respond to complaints.

People were asked about their preferences and activities were arranged in the home.

Is the service well-led?

Requires improvement

There were aspects of the service, which were not well-led.

There were quality assurance systems in place to monitor, identify and manage the quality of the service but there were areas that needed to be improved to make them more effective to ensure people experienced a high standard of care.

CQC were not always informed of notifiable events that had taken place in the home.

Ashfield

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 12 and 17 June 2015 and it was unannounced. The home is registered for 25 people. On the first day, 19 people were living at the home. On the second day, they were joined by two people on a respite stay. The inspection team consisted of two inspectors.

Ten people told us about their experiences of living or staying at the home. Five visitors commented on the standard of the care. We also spoke with the management team and eight staff members. We contacted a health professional who visited the home. 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 comment directly on their experiences of living at Ashfield.

During the inspection, we looked at records relating to monitoring audits which included staff recruitment, staff inductions and supervisions, safety of the building, and risk assessments. We also looked at medication records and the care records for five people.

Before the inspection, we reviewed the information we held about the home and notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. The service did not complete a Provider Information Return about how they ran the service as we brought the inspection forward based on concerns shared with us in June 2015. These concerns related to staffing levels, staff skills and the maintenance of the building.

Requires improvement

Is the service safe?

Our findings

Four people told us they had always felt safe in the home; people walking around the home looked confident and relaxed. However, some areas of risk were not managed well. For example, one person said they felt less safe since a person had come into their room uninvited on several occasions, including at night. On one occasion they said the person had "grabbed my arm once rather tight". Other people commented that a person came into their room uninvited; they said staff helped the person to leave but one person said they had to wait until staff were free to assist them to try and persuade the person to leave. Another person said it was happening less often but daily records showed incidents were still occurring. People showed us their accessible call bells in their room so they could call for staff, if necessary.

Staff identified the person who entered other people's room; their care plan did not have clear guidance to monitor this behaviour or how staff should approach them when they were in the wrong room. The person's daily notes showed they could become frustrated with staff and other people. Therefore guidance to promote a consistent approach by staff may have eased these situations. The manager told us they had already arranged for the person's care to be reviewed by health and social care professionals in recognition that the person might need extra support or alternative care.

Care was not always managed in a safe way. For example, despite checking with staff and the management team an incident report could not be found relating to a vulnerable person living at the home who had recently left the building without staff knowledge. Daily records did not make reference to the event. Later staff confirmed an incident report had not been completed. This meant the log of accident and incidents was not accurate and further work was needed to ensure all events were recorded and risk assessed. Staff also only named one person as being at risk of leaving the building without staff knowledge when records showed this applied to two people living in the home.

Improvements were needed to address environmental risks, including the low height of the washing line, which meant people could have walked into it. A risk assessment stated all cleaning equipment and substances were to be locked away but this had not happened. For example, the sluice room did not have a lock and a small cupboard containing various cleaning products and with chlorine tablets on top of it was also unlocked. Staff told us the key for the cupboard was missing. On the second day, the area remained unlocked with cleaning products still accessible. However, senior staff showed us a lock that was due to be fitted to the sluice door the next day.

The management of medication needed to improve. Medicines were stored in three different places, which included the lounge. This was discussed with the management team because of the temperature in the lounge, which was not currently monitored. It was also highlighted that some medicines were not stored appropriately.

There was no information to identify staff signatures in case there were queries regarding administration. Other improvements were needed regarding dating medicines once opened, observing staff competency, guidance for 'as required 'medicines and ensuring there were consistent charts for prescribed creams. A senior staff member said they would address these issues.

The times of administration were not recorded when medicines were given late. Two medication rounds ran into one as the morning medications continued into lunchtime. We spot-checked stock levels for three medicines and found a discrepancy which indicated a person had not been given one medicine as prescribed. This meant there was a risk this person might not receive their medicines at safe intervals or as intended by the prescriber for ensuring their effectiveness. Other staff said the staff member was responsible for medicines for the morning and afternoon shift so they would ensure tablets were given at appropriately spaced times, but in one case this had not happened.

Staff said there was no current infection control lead whose role could have included monitoring the laundry and sluice room, which needed improvements. The sluice room was cluttered and storage arrangements were limited. There was not a consistent approach by staff to emptying and cleaning commode pots. The laundry had limited space with the hand washing area obscured by stacked laundry baskets and no clear areas to store clean laundry away from dirty items. As a result clean laundry was kept in a downstairs bathroom, which included a toilet used by staff, and a communal area. Weekly cleaning schedules did not include the laundry so there were no records that it was

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Is the service safe?

cleaned appropriately. The dryer was being repaired so some laundry was being sent out to an external laundry. The provider and manager told us they were looking at plans to address the lack of space in the laundry and a builder had visited to assess the area.

Medicines were not managed safely at all times, some environmental and infection control risks and some risks to people's safety were poorly managed. There was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Four people told us there had been a number of changes in the care staff team since the beginning of 2015, which was confirmed by visitors. Records showed seven care staff out of a team of sixteen care staff had started working at the home in 2015, which reflected the changes in the care team. The recruitment files for three of the care staff who had been appointed showed the company recognised the importance of recruiting people who were suitable to work in a care setting. Recruitment records showed all the checks and information required by law had been obtained before two new staff were employed in the home. Additional references had been sought for one person to help the provider judge their suitability. However, for a third staff member there was a gap in their employment history and one reference was not on file, although we were told it had been provided. The management team said they would address these issues.

Staffing levels usually met people's care needs but time spent in communal areas indicated that some people who needed more support required more staff availability at mealtimes. We observed two lunchtime meals and one teatime meal. One lunchtime meal was managed well by staff, with people being supported by staff in an individual and unhurried manner. The second lunchtime meal was disorganised without forward planning for seating arrangements. This meant there was some disruption during the meal as people struggled to move through the room with walking aids. A staff member supported a person with their meal but was regularly interrupted and needed to instruct other staff. There was a lack of oversight by staff of what some people had eaten and poor management of ensuring people had their puddings and refills in a timely manner. This led to some people becoming frustrated or giving up and leaving the room.

It was noticeable during the teatime meal that there was not a consistent staff presence in the room, which meant some people were searching for reassurance. For example, a person looked around at other people for clues as to what they should be doing. They asked "are we ready to start or what?" Eventually they started eating their soup when they saw other people start to eat. Staff popped in and out and tried their best to encourage people to eat and drink but there was no consistent overview. Staffing at this time consisted of two care staff and a senior.

Several staff and a visiting health professional viewed teatimes as potentially problematic because there were not enough staff on the floor. The provider said they felt care staff levels were adequate but said they would consider if another role could be introduced to supplement the care staff. In 2013, staffing levels at this period of the day had been increased but then reduced when people's needs had changed.

Staff took time to speak with visitors and answered their questions during our inspection. Visitors confirmed there were enough staff to greet them and update them on their relative's well-being. For example, "you usually can find someone around." People who were able to comment on their care, generally felt there were enough staff on duty. Changes were being made to increase staff to two waking night staff. The current night time cover was one waking night staff and one sleeping night staff who was called upon when a person needed two people, for example to turn them. Records showed one person could be unsettled at night and needed reassurance from staff and intervention to keep other people safe. The management team assured us recruitment was taking place for a second waking night staff.

People told us staff managed their medication and one said they were offered pain relief on a regular basis. A visitor said they were satisfied their relative's medicines were well managed. There was a safe system to check the medicines coming in and out of the home. Staff described how they were working with prescribers to gain greater clarity over people's allergies being recorded on medicine administration records.

Staff were knowledgeable about how to recognise signs of abuse and how to whistle-blow on poor or abusive practice. Five staff knew who they should contact to make a safeguarding alert either within the company or via an external agency. This included staff working in other roles

Requires improvement

Is the service safe?

rather than care. The phone number for the local safeguarding team was clearly displayed in the hallway so it was accessible to all staff, people living at the home and visitors.

Staff told us about the risks to people's safety and well-being and their responses generally showed a consistent understanding of the risks, such as choking, pressure sores or falling. Staff ensured pressure-relieving equipment was in place for people at risk. While staff who prepared food knew who needed their food prepared in a particular way to reduce their risk of choking. Staff were aware that a behavioural chart was in place for one person to help understand the triggers for their frustration with the aim to reduce these incidents.

The management team explained collating incident and accident reports helped them to manage identified risks. For example, staff told us how a person's falls had been reduced by encouraging them to use communal areas where they could be monitored by staff and assisted as soon as they wanted to stand and leave the room. Advice had also been sought from health professionals to try and reduce the risk of falls to this person resulting in equipment being provided. This approach was confirmed by the person's relative and our observations; the person who had fallen was unable to comment on their experiences.

Personal emergency evacuation plans were kept centrally and these had been updated regarding recent admissions. The manager intended revising these within a fortnight to make information more accessible and to take into account people's mental health/cognition needs as well as their physical needs.

The home was clean and odour free. People told us they were happy with the standard of cleanliness in the home; visitors agreed the home was kept clean with no lingering malodours. Staff were able to explain when they used aprons and gloves and how they disposed of them. Staff were clear how to manage soiled laundry to prevent cross infection.

A handyperson was employed to work at the home; they completed maintenance records, which included weekly and monthly safety checks, such as water temperature and fire safety checks. Staff confirmed breakdowns or other problems were infrequent. On the second day of our inspection, thermostatic valves were being fitted to the basins in people's rooms to reduce the risk of scalding.

Requires improvement

Is the service effective?

Our findings

Three staff said they had not had a recent supervision session to discuss their training needs and the quality of their work. Two staff files connected to staff who had worked at the home for a longer period of time showed supervision sessions had regularly taken place in 2014 but not in 2015. There was no log of longstanding staff receiving an annual appraisal. The manager and deputy who are both new in post had plans in place to address these shortfalls, which staff confirmed. Work had already started to carry out overdue supervisions.

The staff group's skill mix was variable when providing care for people living with dementia. The practice of several staff showed a lack of understanding of person centred care, although their training records showed they had received dementia awareness training. For example, several people became frustrated and complained about staff approach to other people living at the home. One person looked worried and flinched when staff approached them from behind; staff did not change their approach in recognition of the person's body language. A staff member commented that some of their colleagues lacked the necessary skills to respond appropriately to deescalate situations when people became unhappy. This was confirmed by our observations.

Daily records showed a person was "verbally and physically aggressive" towards staff on more than one occasion. Some staff were skilled at engaging with the person and found activities for them to engage in which reflected the person's previous occupation; other staff were more directive and task orientated in their approach. For example, the person rolled their eyes in exasperation when a care worker took their hand to lead them out of the dining room and into the lounge.

There was care information recorded in five people's files, which was individual to them, but it was not always clear if the person or where appropriate a representative, had agreed to the content of care records. Although, one relative told us they had been consulted.

Staff talked to us about their knowledge of how to reduce people's choking risk on food. Two staff did not know what food should be avoided by three people being provided with a soft diet. A third staff member said they had not received training on supporting people who were at risk of choking on food. Staff practice during a lunchtime meal indicated some staff needed further training on general good practice for supporting people with meals, such as not overloading spoons with food and not hurrying people by placing a full spoon by their mouth when they still had a mouth full of food.

In contrast, we met a staff member leaving one person after assisting them to eat in bed. They explained they had sat the person up (using the adjustable bed), and would not be turning them onto their side for a little while to let their meal settle. The staff member said "I try to put myself in their place." The person's food and drink chart had been kept up to date. Several staff could describe appropriate actions, such as not rushing people. Therefore staff practice was not consistent in keeping people safe and comfortable when they ate. On the second day of the inspection, a group of staff attended a food and hydration session to increase their awareness in this area of care.

We looked to see how much space people had access to, particularly as some people regularly walked around the building. The majority of bedrooms were spacious but the space in communal areas was more restricted. The front lounge incorporates a corridor to access bedrooms; the medication trolley and records were stored at the other end of the lounge. This meant staff had to walk in front of the television to access care records and medications. The management team said this was being reviewed. Space was also limited particularly because people needed to be able to reach their walking aids and side tables.

There were two lounges at the home and a dining room. There were tables and chairs for people to use in the home's courtyard, which was the home's only secure outdoor space. Staff described gardening activities and outside lunches that took place in this area. The management team confirmed they were re-considering the current arrangement of staff smoking in the courtyard as a number of people's ground floor bedroom windows opened onto this area.

One person told us they preferred to spend time outside but described the courtyard as "the laundry room" as that day it was full of drying sheets because the home's dryer was being repaired. Communal rooms did not open directly onto this space but staff assured us that in warm weather a fire door was left open so people could access the courtyard. A number of people could walk into the courtyard directly from their bedrooms.

Requires improvement

Is the service effective?

A tour of the building showed there were areas that needed work to improve the standard of décor or needed to be refurbished to meet people's needs. On the second day of the inspection, a sign was placed on a first floor bathroom door stating that it was not in use; the maintenance plan stated it would be refurbished by September 2015. There were two other bathrooms available in the home; one with a walk in shower and one with a bath.

There was no passenger lift in the home and stair lifts were available to access some bedrooms. One person expressed concern regarding the reliability of the stair lift. Staff explained people sometimes needed help to remember how to use the equipment appropriately. After the inspection, the provider said the stair lift had been checked by contractors and no problems were found.

People told us about the skills of the staff who cared for them, for example one person said they felt safe when people assisted them to move. A relative praised the staff group saying "they comfort me very much. If I'm a bit down, they notice and say 'Come on, have a coffee'." Some staff were skilled in their approach, which meant they offered reassurance and support in a way which maintained people's well-being and dignity. A new member of staff spoke positively about a course in dementia care which they had begun since working at the home. Their practice showed they were a good role for model for other staff. The provider told us the aim was for senior staff to share this learning with other staff members. The provider also confirmed six other staff were signed up for a distance learning course on dementia awareness.

Staff received training on a range of subjects including safeguarding adults, the Mental Capacity Act (2005), infection control, first aid, diabetes, health and safety and food hygiene. Training records showed that staff training was generally kept up to date such as first aid and food hygiene. The management team recognised that fire training needed to be reviewed for some staff members and were in the process of addressing this issue.

Some staff felt the resignation of a manager and the cover arrangements had impacted on the planning of their induction but felt the appointment of the new manager would improve how new staff members were supported. Staff told us it was the beginning of a positive time for the people living and working in the home. One staff member said the new manager was "really clued up". The management team told us a new induction process was being introduced to reflect the introduction of the care certificate; staff files and new documentation showed these changes. Staff confirmed they had a period of shadowing other care staff when they started. Several new staff commented on the support from their fellow care workers and good teamwork, with one staff member describing the staff team as "amazing".

The Mental Capacity Act (2005) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

The management team advised there were three DoLS applications in place, which was confirmed by the local DoLS assessment team. However, the team had not been updated on one person's increased risk following a recent event. The new manager had already contacted the health and social professionals involved in this person's placement to update them and agreed the DoLS team needed to be updated. The manager was able to demonstrate their knowledge of when safeguards would be appropriate. A discussion with another staff member confirmed their understanding by giving us examples of their practice. Other staff said they had undertaken training in this subject, which was confirmed by staff records.

One person who had recently come to stay at the home and told us "it is not what I expected" and felt it was not the right place for them. They told us staff had advised them they needed to stay because their relative had made the arrangements. We expressed concern to the manager about the person's well-being and rights given their unhappiness. They said they would consult with the person and social care professionals involved in the stay.

Staff usually checked with people how they wished to be supported and listened to their opinions. For example, the care records for one person included they could not speak in long sentences but could say 'Yes or No'. The records also stated they could still make day to day choices if they were given the opportunity. Staff used closed questions to ask if

Requires improvement

Is the service effective?

they would like a drink, then checked what type of drink they would like to have and where. Some care records showed people were consulted on day to day decisions but other records lacked this detail. People's mental capacity was assessed to support them make decisions in different areas of their care and life, for example the use of an alarmed mat or not going out alone.

People talked to us about the quality of the food at the home and the choices available to them. For example, the chef showed us a separate breakfast menu, which were breakfast items people could have in addition to the usual cereals and bread/toast such as croissants or a sausage bun.

The chef told us there was a file of people's preferences and food allergies. One person's diet and fluid care plan included their dietary 'likes' but also stated the person was able to communicate their choices. It also included that the person might wake in the night and choose to eat at this time. This was confirmed by other staff. Staff involved in food preparation knew people's individual preferences and how to prepare food to suit their preference for texture and appearance.

Practices in the home encouraged people to eat and drink regularly. For example, during the morning, staff in the lounge offered people snacks, such as fruit and cheese biscuits. The chef told us they were informed of any concerns regarding people being underweight and fortified people's food accordingly to increase their calorie intake.

Staff encouraged people to try a fortified milkshake to supplement their main meal; people appeared to enjoy this option by drinking the whole glass of milkshake. People in communal areas and bedrooms had a drink within their reach. Care records showed the staff had regularly contacted a person's GP about a person's weight loss and staff had easy access to information about people's dietary needs

People told us they had access to health and social care professionals; we saw records of visits from people's care records. Health professionals visiting the service included an optician. One visitor suggested staff needed to monitor more carefully that their relative was wearing the correct glasses. Another visitor said they thought staff contacted health professionals promptly when necessary. For example, we saw from one person's recent care notes that staff had contacted the person's GP and an out-of-hours service on the same day because of changes in their physical condition.

Staff generally recognised changes in people's health and made referrals in a timely manner, although a health professional told us staff should have referred a person with pressure care risks to them earlier to ensure appropriate equipment was in place. Since this incident, records showed staff were working with district nurses to meet a person's pressure care needs. Records for re-positioning the person were up to date and appropriate equipment was in place.

Good

Is the service caring?

Our findings

Staff understood the importance of respecting people's dignity and they were respectful when they spoke about how they supported people living at the home. However, one staff member forgot this approach when they mentioned someone's incontinence to another staff member in a crowded room. A tour of the building showed one toilet did not have a working lock which compromised people's privacy and dignity. Staff were discrete when they supported people with accessing toilets. But on one occasion a person's trousers fell down twice in a communal area as they left the room; staff attended to them quickly but it appeared their trousers were too big.

Several people said they would recommend the home to other people. A person said staff were "friendly" and they "had done the right thing" moving to the home. Another person said the staff were "doing their best but they've got their hands full." A person commented to a friend who also lived at the home "very nice ladies, good to me when I want it." Visitors were positive about the attitude of staff, for example telling us staff were attentive and supported people in a manner which maintained their dignity. They said staff were "friendly and welcoming" and one person said their relative had "ate, slept and looked happy" since moving to the home. Another visitor said staff provided not just practical care but affection and gentle humour.

People said staff were kind and respectful when they helped with personal care, although one person said some staff could be gentler. Staff told us how they cared for individuals and they gave examples of their practice. For example, a staff member told us one person did not like water on their face when they were being showered and so they were careful to support them in a way which respected their preferences. Staff spoke about people in a caring manner and it was clear they recognised people's individuality. There were good relationships built between staff and people living at the home, which included gentle banter. People responded well to the staff members' humour.

It was clear from our discussions and observations that most staff knew when to adapt their approach in recognition of people's individuality. Most staff were observant to people's changing moods and responded appropriately, which was demonstrated through their practice. For example, one person in the lounge began shouting occasionally. A staff member went to sit with them and initially reassured them. The staff member then offered them cake, then chocolate, then a rest on their bed, then a drink (which was physically offered as well). They waited patiently for the person's response, before making the next offer. The person chose not to accept any of the suggestions but then became settled. However, some staff needed further training and support to ensure their practice was not orientated to just completing tasks. This had been recognised by the new manager which they said would be addressed through supervisions and positive role modelling by staff with good person centred practice.

Our observations showed how most staff involved people in decision making. For example, a person got up, looking unsteady on their feet though they were using their walking aid which staff had left with them. Staff promptly went to support them, asking them where they would like to move to rather than telling them to sit down again. They waited patiently while the person eventually indicated where they wanted to be, they then assisted them in a safe and caring manner.

Requires improvement

Is the service responsive?

Our findings

There were assessment records for people who were already living at the home but it was unclear who had been involved in the assessment and whether the person moving to the home had been consulted. A visitor told us how a member of the management team had visited their relative at home before a respite stay to assess their relative and discuss their care needs with them and the person. They had found the visit helpful and reassuring. During our visit, the manager visited someone to assess their care needs before they moved to the home.

Two visitors said key information had been shared with the home about risks to their relative's safety but this was not included in their relative's assessment. Another visitor said they used to participate in regular meetings with their relative and staff to review their relative's care but they said this had not happened for some time. Regular holistic reviews of people's care to cover all aspects of their care had not been recently recorded.

The quality of recording people's care needs and how they would be met was variable. For example, there was good practice guidance to staff around one person's dementia care needs linked to staff stepping into their reality and not challenging their perception of events. This was to help prevent distress and unnecessary confrontation with the person. Some staff were skilled at putting this guidance into practice and spoke with the person about their planned holiday and about the care of their small child, which was a doll. The person responded favourably to this approach. Not all staff were aware of the content of the person's care plan which also suggested a short walk could help if they were unsettled. Daily records showed the person had been unsettled but not what had been done in response.

For a second person there was not a clear plan of how staff should respond to the person's restlessness or frustration about being restricted from going out. Their care information stated under emotional well-being for staff to 'give reassurance when anxious'. But there was no clear guidance to staff as to how they should respond to ensure a consistent and effective approach.

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

There was no specific activities worker role at the home; instead an approach had been adopted for one worker to spend periods of time with individuals on a one to one basis to promote people's well-being and engagement. For example, a care worker sat at a table with one person, helping them use modelling clay. Some people also engaged in singing along to songs, which their care records said they enjoyed, as well as playing a musical instrument. Later some people attentively watched a film. There was also external entertainment. For example, three other people appeared to be enjoying an art/craft session during the afternoon led by a relative. However, we also met people who said they slept because they were bored and one said they would "like to go out more".

Activities were not regularly logged, which was confirmed by staff. There was also no overview of how people's interests and well-being was met. There were sensory items in corridors around the home, such a brightly coloured and textured wall and roof hangings, and textured items for people to hold and touch. Staff were unsure how much people interacted with these additions to the home, although they said one person liked a window display at the end of a corridor.

Staff said the complaints procedure was normally on display in the entrance hall but after checking they thought it may have been removed by a person living at the home. A booklet in people's bedrooms included the complaint's procedure but named a manager who was not working at the home. The information it gave regarding the role of CQC was incorrect and did not inform people of more appropriate authorities that could assist them to escalate a complaint. There were also two versions, one with, and one without the contact details of the managing director. However, steps had been taken to update the photos of staff working at the home and to issue staff badges which would help people identity staff that they wanted to praise or complain about.

One person said they had complained about their clothes being damaged in the laundry to staff and a manager but did not feel it had been resolved satisfactorily. One visitor had recently complained about their relative's clothes and belongings being damaged in the laundry but had not received formal acknowledgement of the issue. Neither of the issues linked to the laundry had been logged in the complaints folder. The last entry was dated December 2013.

Requires improvement

Is the service responsive?

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

During our visit, one staff member took time to try and find out what a person was concerned about by using reassurance and a gentle tone of voice. However, on a different occasion another staff member did not recognise that a person was unhappy about their actions and did not address their concerns. Several people and visitors told us they had not needed to make a formal complaint but said they would feel able to make one if necessary.

Requires improvement

Is the service well-led?

Our findings

There have been several changes in the management of the home in the last two years. A new manager started working at the home on 15 June 2015 and said they were in the process of registering with CQC. Exit interviews had not been completed to try and establish the reasons behind staff leaving. Two staff members from the organisation's quality assurance team had covered the manager role for a three month period until a new manager was appointed. During this time they had started making improvements to the quality of the service. Some people living at the home thought the staff from the quality assurance team were going to stay permanently. They were therefore surprised about the appointment of the new manager. As a result there had been significant changes in the management of the home in 2015.

People living and visiting the home were aware of changes in the management team but had not been told formally about the new manager. For example, relatives told us they had not received written information about the changes and were not aware if a meeting was planned to introduce the new manager. There was no information in the home's communal areas advising of the change of management. A 'provider quality check' audit had taken place in April 2015 and identified a survey on the standard of care had not taken place in the last 6 months. The management team said a survey had recently been sent to relatives but there been a poor return; a relative was unaware of the survey.

People living at the home told us there have been a "lot of changes recently" and "we know change is afoot." The manager told us they had spent time on the floor during their first three days at the home and during this time had met informally with people visiting, working and living at the home. They told us a staff meeting was being planned.

Minutes showed there had been seven staff meetings in 2014. In 2015, the management team said meetings had taken place but the recording of staff meetings needed to be improved so that minutes were produced for staff who were unable to attend or to refer to. Steps were being taken to address overdue supervisions, which had been identified in the provider quality check audit. Staff competency assessments had not been completed by the management team to monitor the performance of staff and ensure their practice was safe and caring. However, senior staff said they had visited at different times of the day or worked a night shift to help them make a judgment about how people's care needs were met.

People told us there were resident meetings but could not remember the last one they had been invited to. Records showed two residents' meetings had taken place in 2014 but the last one was seven months ago. Care records did not show that reviews had taken place each month to measure people's emotional well-being, safety and health. Regular reviews to ensure people were happy with the quality of their care and to discuss any improvements that could be made had not recently taken place; this was confirmed by a visitor and records.

The company had a quality assurance team of two operational staff but staff told us the quality of their work had been affected because they had stepped in to cover manager vacancies in homes within the company. The provider told us a third staff member had recently joined the team. They had already completed audits on staff training and recruitment files and work was taking place to action gaps in information.

A provider quality check audit had taken place in April 2015, which included the quality of care records, but the completion of food and fluid charts was not included in this audit. The quality of content for food and drinks records kept for people who were identified as at risk were variable. For example, a person's care records stated that a food chart 'is to be completed daily to monitor (their) food intake'. The records for two weeks were not stored in date order, there were two days missing and there were gaps in the information, which indicated they had not eaten or drunk, although the management team were confident this had occurred. Their weight had been stable but had dipped in May 2015 so it was important to monitor their food and fluid intake effectively.

The management team provided CQC with an action plan resulting from their quality check audit, which had been updated in May 2015 complete with timescales. This was a work in progress. The amount of remedial work to improve the quality of the service indicated that previous quality assurance systems had not been effective or addressed.

External companies had carried out gas, electrical and water safety checks. Records for environmental safety checks, such as those linked to fire, electrical and water

Requires improvement

Is the service well-led?

were difficult to audit as issues had been reported but it was not always clear of what action had been taken. Information was not always stored together and there was not always a clear audit trail to show the work needed to rectify all the issues that gave rise to an 'unsatisfactory' judgement had been completed.

There was a file containing environmental risk assessments, which had last been reviewed four months previously. Spots checks on bedroom windows showed they were restricted and the management team said the manufacturer had confirmed that the fixtures met safety requirements. The management team acted promptly to restrict a window in an upstairs toilet. Monthly checks on restrictors only included bedroom windows and the senior staff said they would address this. During the inspection, a tour of the building was completed both internally and externally; ten bedrooms were spot checked. Four windows and sills were poorly maintained; one bedroom window had a crack in the pane and plastic attached on the inside.

People visiting the home told us they felt their relatives were safe, although two visitors were concerned that there had been incidents when their relative had left the home unaccompanied. In their opinion on one occasion they had not been notified by staff in a timely manner. The registered provider had not complied with their statutory duty to inform CQC of all notifiable events at the home. For example, two incidents involving the police when two people on separate occasions had left the building without staff knowledge and an injury to a person living at the home. Both people had been assessed by staff as being at risk if they were alone outside of the home. However, CQC had been notified about the change of management arrangements and people who had died at the home.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulation 2014.

The provider sent us a building audit, which was dated 10 June 2015 and provided us with a maintenance plan detailing investment in the external structure and internal refurbishment of the home. The audit showed work was planned to address a cracked window and to replace one of the windows. The maintenance plan said further windows would be replaced, which was scheduled for 2016. The hall carpet was also due to be replaced in October 2015.

The management team advised that bedrooms were routinely redecorated as they became vacant and where necessary replaced carpets and refurbished. Empty rooms showed this work had taken place. A room audit completed in February 2015 identified carpets in a number of rooms as needing attention. On the second day of the inspection, work had taken place to replace carpet and flooring in several rooms. The provider advised the carpet fitters were booked up working on other homes belonging to the company and this was why there had been a delay.

Incident and accident reports were audited. A recent medication error had occurred and senior staff confirmed this had been followed this up with the individual staff member.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not assessed some risks to the health and safety of people in receipt of care. They had not ensured environmental risks had been reduced. Medicines were not always managed safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's individual care needs were assessed but reviews had not recently taken place to ensure people's care needs were met and that people were happy with their care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Improvements were needed to record, manage and respond to complaints.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **CQC were not always informed of notifiable events that had taken place in the home.**