Barchester Healthcare Homes Limited

Ashford House

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection that took place on 6 and 7 May 2015. This was a focussed inspection to follow up on actions we had asked the provider to take to improve the service people received.

Ashford House is owned by Barchester Healthcare Homes and is registered to provide accommodation with nursing care for up to 54 people. At the time of our visit, there were 52 older people living at the service. The majority of the people who live at the service are living with dementia, some have complex needs and the service also provides end of life care. The accommodation is provided over two floors that were accessible by stairs and a lift.

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

At our previous inspection on 23 & 25 July 2014 we found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. We asked the provider to take action

Summary of findings

in relation to the standards of cleanliness, infection control, obtaining consent, staffing, supporting staff and assessing and monitoring the quality of the service provided. The provider sent us an action plan on 13 March 2015 and provided timescales by which the regulations would be met. The provider also sent us the updates in relation to progress they had made.

At this inspection we found that some improvements had been made. However, there were still breaches of the regulations. They had not met the requirements regarding cleanliness, and assessing and monitoring the quality of the service provided.

As this is the second time the service has been rated inadequate for one of the five key questions. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

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

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

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

People were at risk because there were inadequate systems and arrangements to protect people from the spread of infection. Appropriate standards of cleanliness were not being maintained. The staff were not following the providers Infection control policies and procedures. We raised concerns about the conditions of mattresses, carpets, chairs, commodes, toilet seat frames and bedding in the home.

People were at risk as their medicines were not administered safely. People were not observed taking their medicines even though the medicine administration records (MAR) sheet were completed. Information had not been recorded if people had refused their medicines. We noted that any changes to people's medicines were prescribed and verified by the person's doctor.

The registered manager ensured staff had the skills and experience which were necessary to carry out their role.

We found the staff team were knowledgeable about people's care needs; however staff's knowledge and understanding of people living with dementia was not sufficient to support their additional needs.

There were inconsistencies in how staff treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit at any time.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at identifying and correcting poor practice.

People told us if they had any issues they would speak to the nurse or the manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

People had access to activities that were important and relevant to them. People were protected from social isolation through systems the service had in place. We found there was a range of activities available within the service and the local community.

People told us that they felt safe at Ashford House. People told us, "Very lucky living here. I feel safe and the staff are good to me." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from abuse.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of people's health. The service worked effectively with health care professionals and referred people for treatment when necessary.

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 this 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?

Requires improvement

The service was not consistently safe.

People were at risk because procedures to prevent and control the spread of infection were not being followed correctly.

Medicines were not managed by staff in a safe way.

People had risk assessments based on their individual care and support needs.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff received training for their role, however their knowledge and understanding of people living with dementia was not sufficient to support people.

People's human rights were protected as restrictions were in accordance with appropriate guidelines.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services.

Staff provided care, treatment and support which promoted well-being; however there were inconsistencies with the level of care and support provided.

Is the service caring?

Requires improvement

The service was not consistently caring.

People's privacy were respected and promoted. Staff involved and treated with compassion, kindness and dignity. However, there were occasions were people's dignity was not upheld.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

There was detailed information about the care, treatment and support people needed and received. However, not all staff responded to peoples needs in the right way.

People were encouraged to voice their concerns or complaints about the service and they were dealt with promptly.

People's needs were assessed when they entered the service and reviewed regularly. Care records were updated by staff involved in their care.

People were able to pursue their interest and hobbies that were important and relevant to them.

Is the service well-led?

Inadequate

The service was not well- led.

The provider had systems in place to regularly assess and monitor the quality of the service provided. However, the system and cleaning schedules did not did not highlight the poor cleaning practices we observed.

The provider had sought, encouraged and supported people's involvement in the improvement of the service. Action taken had been recorded so people knew what the concerns had been, or how they were being addressed.

People told us the staff were friendly, supportive and management were visible and approachable.

Ashford House

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.

We visited the service on 6 May 2015 and it was an unannounced inspection. We returned to the service on 7 May 2015 to see whether improvements had been made in relations to the concerns raised on 6 May 2015.

The inspection was conducted by two inspectors and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service

We spoke to 12 people who use the service, 11 relatives, 11 staff including nurses, care workers, housekeeping staff and management. We observed care and support in communal areas; we looked at 10 bedrooms with the agreement of the relevant person. We looked at five care records, risk assessments, seven medicines administration records, accident and incident records, minutes of meetings, complaints records, policies and procedures and external and internal audits.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We contacted the local authority and health authority, who had funding responsibility for people using the service. We also contacted three social care professionals who visited the service to obtain their views about the service.

Requires improvement

Is the service safe?

Our findings

At our last inspection on 23 & 25 July 2014, we identified breaches of Regulations 12 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to have effective systems in place to assess the risk, prevent and control the spread of infections. They had also failed to take the appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed.

We asked the provider to take action to make improvements to their infection control procedures and review the number of staff employed. The provider sent us an action plan stating they would make the improvements by 31 March 2015.

At this inspection we found that some improvements had been made. There were enough staff deployed to ensure that people were protected from the risk of harm. However, we found that the provider had not made all of the improvements to their infection control procedures.

People were not safe because the systems in place to prevent and control infection were inadequate. Although the provider had systems to ensure appropriate standards of cleanliness were maintained, not all of these were being followed, which was having an effect on the standard of cleanliness throughout the service. For example, there was a smell of urine coming from a number of rooms we visited, some of the carpets, chairs, bed buffers, bed frames, mattresses and bed linen in people's rooms were stained or soiled with bodily fluid.

Infection control policies and procedures were in place; however we observed staff not following these procedures. There was a cleaning schedule for the service. These detailed the different activities that needed to be carried out and checked. Staff had signed when tasks had been completed, however it was clear there was no effective monitoring of the work carried out.

Although protective equipment such as aprons and gloves were in place we saw some staff wearing disposable aprons and gloves, and others did not. We also saw some staff conducting domestic tasks without wearing the appropriate personal protective equipment (PPE) to protect themselves or people from cross contamination. For example we saw a member of staff about to clean a soiled mattress without wearing any PPE to protect themselves or others. Antibacterial gel, hand wash and paper towels were available throughout the service for people to use to help reduce the amount of bacteria found on their hands.

Most staff were seen to be 'bare below the elbows', this is to ensure that people providing care and support are not wearing anything to hinder washing their hands effectively. Some staff were seen wearing jewellery such as rings and watches, these items could harbour germs and bacteria. This meant people and staff were not adequately protected from the risk of infection because best practices had not been followed.

We raised concerns with the registered manager about the conditions of some of the commodes and toilets seat frames. We saw that some of them were covered in rust, limescale and soiled with bodily fluids. This made it difficult to clean effectively to help reduce the risk of infection.

We noted that hoist slings were used and stored on a shelf in a public corridor. We were told that there were only two slings for use by everyone living on the floor, which meant that people did not have their own personal slings. We saw staff use these hoist slings to assist people and then return them to the shelf without disinfecting them between uses. This could pose a risk of cross contamination. We raised all of our concerns with the registered manager.

Failure to have effective systems in place to prevent and control infection safely was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not managed by staff in a safe way. We observed that some people were not administered their medicines safely. For example people were not observed by staff when taking their medicines even though the medicine administration records (MAR) sheet were completed. This meant staff could not be sure the medicines had been taken. Information had not been recorded if people had refused their medicines. For example, a person was given multiple tablets simultaneously and spat them out. This meant that the person was not only at risk of not receiving their medicine but could have caused them to choke.

Requires improvement

Is the service safe?

We looked at the MAR sheets to see if they were used appropriately. Apart from the above concerns we noted there were no omissions and gaps on the MAR sheets. We saw that documentation that recorded information about people who had medicines administered covertly was not fully completed. The administration of Covert medicines is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it. For example, no information was provided about why the medicine was necessary, if an assessment to confirm whether the person lacked capacity to give consent had been carried out or whether there was a person available with legal power to consent on behalf of the person.

Failure to manage medicines safely was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The storage and administration of all drugs were in accordance with National Institute for Health and Care Excellence (NICE) guidelines and the requirements of the Misuse of drugs (Safe Custody) Regulations 1973. There were written individual PRN [medicines to be taken as required] protocols for each medicine that people took. These provided information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. The procedures in place meant people should receive their medicines in a consistent way

A relative told us, "I feel that X is very safe here, for example, X kept putting their legs over the edge of the bed and kept falling out. They have put a protective mattress on the floor and are monitoring X more closely." Staff had been provided with information and guidance about how to manage people's risks. Risk assessments provided details about the risk, and what actions to take to minimise the risk. We noted that a number of people had complex needs and needed one to one support from staff to minimise harm to themselves and others.

There was a staff recruitment and selection policy in place and followed. Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provide proof of identification and contact details for references. The provider ensured that the relevant checks were carried out to ensure staff were suitable to work at the service. Staff confirmed they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained. Staff confirmed that they attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

We saw that there was sufficient amount of staff to meet people's needs. A person told us, "I would like help to come quicker but usually it is not too bad." A relative said, "There are generally enough people around but we have to wait during certain times of the day. It's difficult because X needs two carers to hoist her and move her about and that's where any problems start." We saw that additional staff has been recruited. We reviewed the staffing rota and saw that additional duties had been added. We saw that the provider had made all of the improvements that were required to meet the requirements of the regulation.

People told us the staff were very good and they felt safe with them. One person told us, "I am very lucky living here. I feel safe and the staff are good to me." A relative told us, "I feel that my Mum is cared for and that she is safe." Leaflets about different types of abuse and how to report it were displayed on noticeboards in the service. This meant people were provided with guidance about what to do if they suspected abuse was taking place.

The service had a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults. This provided staff with up to date guidance about what to do in the event of suspected or actual abuse. The provider had also obtained and followed external guidance from the Department of Health. Staff told us that they had received safeguarding adults training within the last year. We confirmed this when we looked at the staff training programme. Staff knew what to look for and what to do if they suspected any abuse. A member of staff told us, "I would talk to my manager, who would inform the local authority."

We observed information displayed regarding the Fire Evacuation plan. We saw in people's care plan a 'Personal Emergency Evacuation Plan' had been completed. This meant that staff had information on how to support people in the event of an evacuation.

Requires improvement

Is the service effective?

Our findings

At our last inspection on 23 & 25 July 2014, we identified breaches of Regulations 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person had failed to have suitable arrangements in place in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. They had also failed to have suitable arrangements in place in order to ensure staff are appropriately supported in their role.

We asked the provider to take action to make improvements to their infection control procedures and review the number of staff employed. The provider sent us an action plan stating they would make the improvements by 31 March 2015.

At this inspection we found that the provider had made all of the improvements that were required to meet the requirements of the regulations.

The registered manager understood their role and responsibilities with regards to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. DoLS provide a legal framework to prevent unlawful deprivation and restrictions of liberty. They protect people in care homes and hospitals who lack capacity to consent to care or treatment and need such restrictions to protect them from harm.

We found there were policies and procedures in relation to MCA and DoLS and staff had received training. We found that DoLS applications both urgent and standard had been completed and submitted to the local authority in accordance with legislation to ensure people's care did not compromise their human rights. We saw consent agreement forms for care and treatment recorded in care plans. People's rights were protected when they were unable to make decisions for themselves.

There were qualified, skilled and experienced staff to support people living at the home. The registered manager ensured staff had the skills and experience which were necessary to carry out their roles. Staff confirmed that a staff induction programme was in place. We found the staff team were knowledgeable about people's care needs; however the service has a high proportion of people living with dementia, had complex needs and whose behaviour challenged the service. Staff only had the basic understanding of dementia which was not sufficient knowledge to support people living with various stages of dementia and complex needs. For example an understanding of the different types of dementia people are experiencing, how this impacted on their life, affected their behaviour and how to support them.

One person told us, "Having moved homes to here, the staff are far more caring and knowledgeable but it still has a long way to go in terms of understanding dementia and training." Another person told us, "Caring people here, but I would like to see a dementia specialist here."

We recommend that the provider reviews current best practice, in relation to the specialist needs of people living with dementia and other complex needs.

During our observations, we saw two members of staff using equipment to transfer a person with limited mobility from a chair to their wheelchair. This was carried out sensitively and skilfully. During the process the person was constantly reassured and told what was happening. Conversations with staff and further observation of transfer techniques confirmed that staff had received training and that they had sufficient knowledge to enable them to carry out their roles safely and effectively.

People told us they felt supported and staff knew what they were doing, a person said, "The people here seem to know what they are doing they treat me well." A staff training chart showed that all staff had been trained in areas relevant to their role such as medicines awareness, safeguarding, moving and handling, fire awareness, first aid, food hygiene, Cardiopulmonary resuscitation (CPR) health and safety, infection control, dementia awareness, Mental Capacity Act and Deprivation of Liberty Safeguards. Staff confirmed that they had received the training which enabled them to do their role.

Staff told us they had regular meetings with their line manager to discuss their work and performance. A member of staff said, "We have supervision every 3 months, I have had 2 since I have been here." The registered manager confirmed that supervision took place with staff to discuss

Is the service effective?

issues and development needs. We reviewed the provider's records which reflected what staff had told us. This meant that staff had the opportunity to discuss their role and any areas of concern with their manager.

People told us about the food at the home, one person told us, "Food is good here but sometimes too much for me." A relative told us, "Very good food here. He enjoys his food and is starting to put on a bit of weight." People had their nutritional needs assessed and specific care records had been developed in relation to their individual needs. For example, where people needed assistance with eating or had special dietary requirements, such as allergies or had a risk of choking, information and guidelines were recorded to ensure that people's needs were met. We noted products and instructions were available for people who required their food and drink to be thickened which enable them to eat and drink without choking.

People were offered a choice of menu for breakfast, lunch and tea. The menu only had written information to describe the meals on offer and lacked other formats such as pictures which could help some people make a more informed choice. There was a choice of suitable and nutritious food and drink available throughout the day. We noted that soft or pureed food was presented in an appetising form. We noted that juice dispensers had been installed so people could help themselves. The portion size varied according to the person's wishes and second portions were available. Staff confirmed that snacks were available at any time as some people preferred to have a snack rather than eat a large meal. People confirmed that they had sufficient quantities of food and drink.

People were supported to have their nutrition and hydration needs met. A relative told us, "My relative's food and fluid charts are filled in." Care records contained information about people's food likes and dislikes and preferences such as religious or cultural needs. People's nutritional intake was also assessed and monitored; this information was given to the staff who prepared the meals. We saw information displayed in the kitchen about people who had special dietary requirements such as diabetes, high calories, low salt or gluten free and health conditions that required pureed or softened food.

We saw staff assisting people to get ready for lunch, at a slow and steady pace, they were not rushed. People who were unable to eat independently were supported by a member of staff. Throughout the day people were encouraged to take regular drinks, to ensure that people were kept hydrated.

People had access to healthcare professional such as doctors, district nurse, occupational therapist, physiotherapist, and other health and social care professionals. A relative told us, "X gets to see a doctor straight away if she needs one and they always keep us fully informed." Another relative told us, "Very safe here. X has a specific problem ingesting food. Any problems with this and she is taken straight to hospital for emergency care. Staff react well and quickly." Staff told us the local doctor visited weekly or when required and those who wished to see their own doctor were supported to do so. We saw from records that when people's needs changed, staff obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in the care records. This showed the management and staff ensured people's health needs were met.

Requires improvement

Is the service caring?

Our findings

We found during our observations there were inconsistencies in the care that was provided resulting in poor practice. Staff were very busy which had an impact on the support provided. We saw distressed people shouting out and calling for help being ignored by staff walking past their rooms. This meant that staff were not responsive to people care needs. We also noticed some staff shouting across the room to each other which added to the noisy atmosphere created by some people who were shouting or using aggressive language. We also saw some staff talking down to people in a way that was not respectful, such as telling them what to do. This demonstrated that staff did not always create a calming atmosphere or treat people with respect.

Failure to treat people with dignity and respect is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed examples of good care given to a person who was upset and the member of staff knew exactly what support was needed. Staff placed the person in a different position and sat holding their hand until the person was reassured and calmed. Staff were aware of peoples' wishes through non-verbal communication. Through our observations we saw staff used the correct manual handling techniques and they were aware of the need to maintain a person's dignity during the lifting procedure. For example we saw clothing was re-arranged before and during the lift in order to ensure that the person's dignity was preserved.

Relatives commented on the care their relatives received. One relative told us, "Brilliant care here. There are girls and boys coming from different parts of the world, caring so well. It makes your heart want to pop." Another relative told us, "Good care –X is very confused but relates well to the girls. She can tell you if she is uncomfortable and the girls will come straight away and change her." Another relative told us, "I am pleased with Mum's care. She is clean, tidy and well fed and people are so kind to her."

People told us staff treated them with "kindness and compassion." A relative told us, "They listen to what people want. Mum likes to be quiet she doesn't like to talk much so they make sure that mum is taken to the quiet lounge during the day where she is happy." Staff called people by their preferred names, and when personal care was given this was in private. Staff explained to people when they were going to assist someone, such as moving them with a hoist. At each stage they checked the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner and involved people in light hearted and appropriate repartee.

Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed. We saw detailed information in the care records that highlighted people's personal preferences, so that staff would know what people needed from them. Staff knew people's religious, personal and social needs and preferences from reading their care records. We noted that care records were reviewed on a monthly basis, so that staff had up to date information about the care and support people required in accordance to their needs.

People were involved in making decisions about their care. We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks, or choice of meal. Staff did not rush people for a response, nor did they make the choice for the person. Relatives told us, "They keep me fully informed of any concerns or any changes to his care plan. We consult regularly about his behaviour plan." Another relative told us, "I see her personal care plan/records regularly and I am consulted about planning her care."

Relatives and friends were encouraged to visit and maintain relationships. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. We also saw that religious services were held in the service and these were open to those who wished to attend. This showed us that care and support was provided with due regard for people's religious persuasion.

The service also provided care to people when they were very ill or approaching the end of their life. A relative told us of their experience of the service when their relative's health was deteriorating rapidly. "We were called in by staff. Staff gave her round the clock care, popping in and out regularly. There were no restrictions on us we could come day or night. She has continued to recover thanks to the care given to her."

Requires improvement

Is the service responsive?

Our findings

In the majority of the rooms call bells were within easy reach for people, but many people had limited mobility and therefore relied on staff who conducted regular checks to their rooms to check if they needed assistance. Therefore people could be waiting a long time for their needs to be responded too if they were unable to raise the alarm for assistance. There was no monitoring or reviewing of the call bell system to be able to identify patterns or trends occurring.

We saw that although care and support were provided to people living at the home. Care was not individualised enough to provide additional person centred care for people living with dementia and complex needs. For example how different types of dementia impacted on people's life, affected their behaviour and how to support them. We saw that information was provided in written form and not in pictorial format which would assist people who have dementia or sensory disabilities to make an informed choice.

People told us they were able to make their own decisions about bedtime and they could choose when they got up in the morning. A member of staff was responsive to a person as they wanted some biscuits, so he made sure that the other people were supported by another member of staff before he went and obtained some snacks.

We saw that each corridor had a theme which consisted of photographs and items which people could touch were designed to recall people's memories and aid discussions. The service also had a sensory room that was equipped with items that created sensations that could assist relaxation, or stimulate people's senses. A member of staff told us, "This room works well for the residents. They find it calming and relaxing." People's rooms were personalised, they had photographs of family, pictures and items of religious sentiment and personal choice.

The service had their own transportation and there was a range of activities on offer together with mini-bus trips to places of interest. The activities reflected people's interests and hobbies such as, sewing, cooking, basic fitness/ physical activity and art therapy. There was a good deal of photographic evidence on the wall to confirm that activities had happened such as summer garden party. A person told us, "Always things to do and it stops me from getting bored." A relative said, "The activities person is brilliant; there are lots of different activities going on."

Reminiscence boxes were available to help people recall memories. Each box contained photographs and personal items that were meaningful and personal to the individual. During our visit we saw a musical activities session taken place, people were using percussion instruments and singing. The musical theme was based around V.E. day. One person told us, "I love the old songs it bring back so many memories." Other people told us how much they had enjoyed the session. People, with limited capacity for speech were smiling and their body language indicated that they were enjoying the event. Arrangements were in place to reduce the risk of social isolation and loneliness such as weekly visits from the religious community. 'Pets as therapy' visited people who lived at the home and staff encouraged family and friends to visit.

Assessments were carried out before people moved into the home and then reviewed once the person had settled into the home. The information recorded included people's personal details and whether people had capacity to make decisions. This was reviewed on a regular basis as people's capacity could vary from to time. Details of health and social care professionals involved in supporting the person such as their doctor and or care manager were recorded. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had up to date information.

People were provided with the necessary equipment to assist with their care and support needs such as wheelchairs and hoists. People and relatives confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. Information was also recorded if any changes had happened such as: wound care, falls, medicines, incidents, accidents and dietary needs.

People told us they knew what to do if they needed to make a complaint. A relative told us, "If I have any worries, and there have been minor ones so far, then the manager will listen and sort things out as and when." Information

Requires improvement

Is the service responsive?

about the complaints procedure was provided in the 'residents' handbook; it also provided contact details for the local government ombudsman and the Commission. We saw that information was provided in written form and not in pictorial format which would assist people who have dementia or sensory disabilities to make an informed choice.

Staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint. A relative told us, "Mainly a problem with clothes going missing. I've bought X two pairs of slippers and both have disappeared. I told the staff but they've searched but can't find them. I can't keep buying more.' We followed this up and found that staff had responded to this complaint but that it is still an ongoing issue.

Another relative was concerned that prescribed material had gone missing from a locked cabinet. They had raised this issue with staff, who have taken the complaint seriously, and as yet it has still not been found. This was still an ongoing issue. The majority of relatives we spoke to were confident that they would be taken seriously and that their issues would be addressed in a timely manner.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 23 & 25 July 2014, we identified breaches of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person did not have effective arrangements in place to protect people by regularly assessing and monitoring the quality of the service provided and identifying, assessing and managing risks.

We asked the provider to take action to make improvements. They sent us an action plan stating they would make the improvements by 31 March 2015.

At this inspection we found that the provider had not made all of the improvements that were required to meet the requirements of the regulations.

The systems in place to monitor and review the cleaning tasks and cleaning standards were inadequate. The audits carried out in April 2015 had contradictory information when reviewing and monitoring the cleaning standards. There was no record of any actions taken regarding the findings made. This meant that there were no robust or effective systems in place to protect people from the risk of infection or to ensure the standard of cleanliness in the home.

A review of the quality assurance systems in place to monitor and review the management of medicines, found the systems in place were not robust to protect people from improper care. We reviewed five Medication Administration record (MAR) Audit tool reports which review individual service users medicine record and recorded their findings but there was no record of actions completed.

The arrangements in place to monitor the cleaning of equipment such as mattresses and hoists were not consistent. Therefore there was no systematic overview of the cleaning of necessary equipment to support people's needs.

The manager's Quality Assurance report completed in February 2015 identified issues relating to the management of medicines, there was no recording of action taken. This meant that although systems were in place there were no systematic arrangements in place to monitor actions taken.

Failure to have robust and effective systems in place to protect people from harm was a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monthly audits which covered areas in health and safety, clinical governance, medicines, facilities, spot checks, care records, and an additional medicines audit conducted by an external agency.

People were involved in how the service was run in a number of ways. People told us that they had attended 'residents' meetings, where they discussed the service provided such as choices of food, activities, care provided and the garden. Relatives told us there were 'relatives' meetings where they could discuss suggestions or raise concerns about the service. We noted from minutes of a relatives meeting held in March 2015 they discussed issues regarding the service. For example: chairs and cleaning; personal care; bedroom cabinets and laundry.

Staff told us there were regular staff meetings where they were encouraged to raise their concerns about the service. We saw minutes of the staff meeting that noted items raised and discussed such as activities for people, instructions regarding infection control, and facilities used whilst assisting people with personal care tasks. We saw notes of head of department meetings that took place on a daily basis to discuss issues regarding the service and actions agreed.

The provider had arrangements in place to conduct announced and unannounced visits to the service which were carried out by the registered manager and senior manager. The report written by the registered manager highlighted their findings; issues raised and follow up action to be taken. However, there was no record of any action taken to address reoccurring issues. The senior management visits reported their findings. Some findings such as training attendance was improving, however signatures regarding medicines administered was still an on-going issue. The provider had a system to manage and report incidents and accidents. Members of staff told us

Inadequate

Is the service well-led?

they would report concerns to the nurse in charge or to the registered manager. We saw incidents and safeguarding had been raised and dealt with and notifications had been sent to CQC in a timely manner.

A relative told us, “Staff are much happier, more smiling. I know that they have much better leadership - a big difference over the last few months. The manager is there to talk to us.” Another relative told us, “The manager is very approachable and will deal with any issues.” We saw that the registered manager had an open door policy, and actively encouraged people to voice any concerns.

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 The registered person did not ensure that people were treated with dignity and respect. **Regulation 10 (1)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe management of medicines. **Regulation 12 (1)(2)(g)**

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 The registered person had failed to assess, monitor and improve the quality and safety of the services provided and did not migrate the risks relating to health, safety and welfare of service users and others who may be at risk. **Regulation 17 (1) (2) (a)(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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Safe care and treatment The registered person had failed to have effective systems in place to assess risk, prevent and control the spread of infections, including those that are health care associated. **Regulation 12 (1) (2) (h)**

The enforcement action we took:
A warning notice has been issued.