Indigo Care Services Limited

Ashlea Lodge

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

Summary of findings

Overall summary

The inspection took place on 5 and 12 December 2016 and was unannounced. This was the first inspection of the home since the current provider took over management in April 2016 and the first rating inspection for this home.

Ashlea Lodge provides residential care for up to 40 older people, some of whom are living with dementia. At the time of this inspection there were 35 people living at the home. A new provider took over management of the home in April 2016.

The home did not have a registered manager. A new manager had been started their employment at the home three weeks prior to our inspection. They had applied to the CQC to become the registered manager. 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.

During this inspection we found the provider had breached the regulations relating to safe care and treatment and good governance. We found the arrangements for managing medicines were not always safe. Medicines records were not always completed correctly, such as for the administration of medicines, application of topical creams, stock control and for the safe storage of medicines. We found medicines care plans were not always accurate or up to date. One person had received their medicines incorrectly on two occasions in the last month. Risks had not been adequately assessed as the assessments we viewed were inaccurate. Where measures had been identified to keep people safe, evidence was not always available to confirm these had been actioned. For example, some care plans had not been written or contained inaccurate and out of date information. We also found there were gaps in records and some essential records had not been kept, such as fluid charts. We observed an occasion where care workers did not follow a person's care plan to reduce their anxieties.

The new provider took over management of the home in April 2016. They contacted the CQC to advise that due to the poor standards they had inherited an improvement plan was to be brought forward. When we inspected the provider had made significant progress against the actions identified in the plan. For example, actions to ensure all relevant people had the appropriate MCA assessments and best interest decisions, all staff had completed essential training, recruiting additional care staff and domestic staff and the appointment of a new manager. Other actions were still on-going at the time of our inspection. The provider submitted a revised action plan following our inspection which reflected the concerns we found during the inspection. The provider agreed to also submit a weekly progress update to ensure close monitoring of the outstanding actions and to meet the requirements of the regulations.

People, relatives and care workers told us there had been improvements made to the home since the current provider took over. They said the home was cleaner and the quality of meals had improved.

In May, August and November 2016 we received anonymous concerns relating to medicines management, moving and handling, high turnover of staff, cleanliness, people not being encouraged to eat their meals, people's individual care, care plans lacking meaningful information and the management of the home under the previous provider.

People and relatives told us the home provided good care. They also told us care workers were kind and caring and knew people's needs well.

Care workers understood the importance of treating people with dignity and respect and encouraging people to be independent. They gave us examples of how they aimed to promote this when caring for people.

We saw care workers used safe moving and handling techniques when supporting people to mobilise. Where concerns had been identified, disciplinary procedures had been initiated to investigate the concerns. The provider took action to help prevent people from falling.

Staffing levels had been increased following the recruitment of new care workers and ancillary staff. Care workers told us the staffing levels were much better now and they had time to interact and socialise with people.

The home was clean with no unpleasant odours. Dedicated domestic staff had been recruited and these were visible undertaking cleaning duties when we visited. There were ample supplies of cleaning materials available for domestic staff to use. Relatives and care workers told us cleanliness had improved since the new provider took over.

Care workers did not have any concerns about people's safety. They felt people were safer now than before. Care workers knew how to raise concerns through the provider's whistle blowing procedure and said they felt their concerns would be taken seriously. A safeguarding log had been implemented as this had not previously been in place.

The provider had effective recruitment checks. This included requesting and receiving two references and Disclosure and Barring Service (DBS) checks to ensure new care workers were suitable to work with people using the service.

Health and safety checks were carried out regularly and were up to date when we visited. These included checks of fire safety, specialist equipment, the electrical installation, gas safety, water safety and portable appliance testing. The provider had specific procedures to deal with emergency situations.

People and relatives gave only positive feedback about the meals provided at the home and commented about the improvements the provider made. Generally people received the support and encouragement they required to have enough to eat. We observed a small number of occasions when care workers missed cues that people required support. We also observed people were not routinely offered a choice of drinks to accompany their meals. If people did not want to have any of the meal choices on the menu alternatives were offered.

Care workers told us they received good support and the training they needed. Regular supervisions were now taking place so that care workers had opportunities to discuss their role and development needs. Training records showed training was up to date.

The provider was following the requirements of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). The provider had taken action to ensure all relevant people had the appropriate DoLS authorisation in place. MCA assessments and best interest decisions had been documented where decisions had been made in people's best interests. Care workers understood how to support people with making choices and decisions.

People had access to external health professionals, such as GPs, specialist nurses, district nurses and dietitians.

A new activities co-ordinator had recently started employment. They had plans to develop activities in the home including developing links with the local community. Records showed people were involved in a range of activities such as quizzes, sing a longs, watching films, arts and crafts and manicures. We observed activities were on-going during our visit to the home.

The provider had a complaints procedure which was available to people using the service. Previous complaints had been investigated and resolved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines records did not support the safe management of medicines. Risks had been inaccurately assessed. Controls to manage risks were not always put into action.

Care workers used safe moving and handling techniques when supporting people to mobilise.

Care workers told us the staffing levels had increased and were now much better. New care workers were recruited safely.

The home was clean with no unpleasant odours. Relatives and care workers told us cleanliness had improved since the new provider took over.

Regular health and safety checks were carried out to help keep the building safe for people to live in.

Is the service effective?

Requires Improvement

The service was not always effective.

People and relatives said improvements had been made to the meals provided at the home.

We observed a small number of occasions when care workers did not respond quickly to support people with eating. People were not offered a choice of drinks to accompany their meals.

Care workers said they received the support and training they needed. Regular supervisions were now taking place and training was up to date.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS).

People had access to external health professionals when required.

Is the service caring?

Good

The service was caring.

We observed an occasion where care workers did not follow a person's care plan to reduce their anxieties.

People and relatives were happy with the care provided.

People told us care workers were kind and caring. .

Care workers understood the importance of treating people with dignity and respect and promoting independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans required to meet people's needs had not been written. Other care plans contained inaccurate and out of date information.

People had opportunities to participate in activities if they chose to. The activity co-ordinator was developing links with the local community.

Complaints were dealt with thoroughly following the provider's complaints procedure.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider failed to keep accurate and up to date care records to account for the care people had received. We also found gaps in records and other essential records had not been kept.

Care plan audits had been ineffective in addressing the inaccurate and out of date information in care records.

The provider brought forward an improvement plan due to the poor standards in the home which they found when they took over in April 2016.

The provider had made significant progress against the actions identified in the plan to date.

People, relatives and care workers told us there had been improvements made to the home.

Ashlea Lodge

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 5 and 12 December 2016 and was unannounced.

The inspection was carried out by one adult social care inspector, a pharmacist inspector and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Health Watch.

The provider completed a provider information return (PIR) prior to 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.

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

We spoke with six people who used the service and five relatives. Most of the feedback we received was from relatives as people using the service had difficulties telling us about their experiences. We also spoke with the manager, the deputy manager, a senior care worker, four care workers, two night shift agency care workers and the activity co-ordinator. We looked at a range of records which included the care records for five people, medicines records, recruitment records for five care workers and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

In May 2016 we received anonymous concerns about the way people's medicines were managed. In particular, medicines had been found on the floor in communal areas and some people were not supervised to ensure they had their medicines. Although we found no evidence of this happening during our inspection we did find other concerns relating to medicines management.

We looked at the arrangements for the management of medicines and found the arrangements were not always safe. Records relating to medicines were not always completed correctly placing people at risk of medicines errors. Medicine stocks were not always properly recorded when medicines were carried forward from the previous month. For example, care workers had documented a figure of 52 tablets in stock however only eight were left in stock. This was necessary so accurate records of medication were available and care workers could monitor when further medication would need to be ordered.

When we checked a sample of medicines alongside the records for people, we found four medicines for two people did not match up so we could not be sure if people were having their medicines administered correctly.

We looked at the medicines administration record (MAR) for one person prescribed a medicines patch that was to be administered daily. There was a system in place for recording the site of application using a patch application record; however patch removal was not always documented. Care workers were rotating the site of application but the same area had been used more than once in 14 days which is against manufacturer's guidelines.

We looked at the current medicines administration record for one person prescribed a medicine with a variable dose, depending on regular blood tests. Written confirmation of the current dose was kept with the person's MAR. Care workers were able to check the correct dose to give however the record we looked at did not demonstrate this was always followed. For example, records showed the person should have had a dose omitted on 30th November 2016 but the medicine was still administered. For the same person the wrong dose of medicines had been administered on two occasions in the last month. The provider was using two different forms of recording documentation which made records hard to follow. We checked the stocks of this medicine on the day and found they did not match with records meaning we could not be sure this medicine had been administered correctly. We looked at two other variable dose records which showed care workers were not always recording the dose administered. Therefore we could not accurately identify the dose the patient had received.

We also saw how the care home managed the application of creams. Although the home had a policy stating there should be a topical medicines application record in place, with information on where to apply, frequency of application and two signatures, the guidance we saw was incomplete.

We looked at care records and found they were not always accurate. For example, we found two medicine care plan reviews had taken place in November 2016 for medicines that had been stopped in September

2016.

We looked at the guidance information kept about medicines to be administered 'when required'. Arrangements for recording this information were in place for some people. However, some of these records were not fully completed. For example, we looked at one record for a person who could not communicate verbally if they required pain relief or their inhaler. This person had 'when required' guidance in place but this was not fully completed. Therefore staff could not identify signs when medicines would be required. We looked at another record where no 'when required' guidance was in place for a person requiring pain relief. Care staff were not recording details on the reverse of the MAR of 'when required' administration as detailed in their medicine policy. This information would help to ensure people were given their medicines in a safe, consistent and appropriate way.

Medicines which required cold storage were kept securely in the fridge within the medicines store room. Temperatures were being recorded daily but there were gaps in recording. For example, over the last three months no temperature had been recorded on 18 occasions. All temperatures recorded were the same value suggesting the fridge had not been reset correctly. The home did not record the minimum or maximum temperatures.

Staff knew the required procedures for managing controlled drugs. We saw controlled drugs were appropriately stored and signed for when they were administered. However, care workers were not completing monthly controlled drug stock checks as detailed in the provider's medicines policy.

Eye drops, which have a short shelf life once opened, were not marked with the date of opening. This meant that the provider could not confirm that they were safe to use.

We looked at how the manager monitored and checked medicines to make sure they were being handled properly and that systems were safe. We found that whilst a daily MAR audit sheet was completed issues were not always identified.

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

Medication Administration Record (MAR) contained photographs of people to reduce the risk of medicines being given to the wrong person.

Risks to people's safety were not adequately assessed and managed placing people at an increased risk of receiving inappropriate care. The provider carried out standard assessments to help protect people from a range of potential risks. A recognised tool was used to assess whether people were at risk of poor nutrition. We found these assessments were inaccurate for all five people whose records we checked. For example, for one person an incorrect height measurement was used which meant the Body Mass Index (BMI) calculated and therefore the overall risk score were incorrect. For another person care workers had not included the person had experienced a significant unplanned weight loss when assessing their risk. This meant the overall assessments for these two people indicated a lower risk than the actual risk to the people. The provider told us they had already identified concerns regarding care workers' competency to use this tool effectively. As a result action had been taken to improve the accuracy of these assessments. This included implementing a specific training programme for relevant care workers. Care workers had also been directed not to complete this tool until they had been assessed as competent to do so.

The provider used another recognised tool to assess people's risk of skin damage. We also found these

assessments were inaccurate. One person's assessment carried out in August 2016 showed their risk of skin damage had increased from low risk to medium risk. The guidance on how to use the tool stated, for medium risk, care staff must implement a care plan. We found when we inspected in December 2016 a care plan had not been written to guide care workers about the care the person needed to protect their skin. Another person had been assessed as at a higher risk of skin damage because they were 'immobile' and 'chair bound'. The new manager advised us the person's assessment was inaccurate as the person did not have problems with mobility. This meant there was a risk people may not receive the correct care to ensure their needs were met.

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

In May 2016 we received anonymous concerns that some people had experienced preventable falls. In November 2016 we received further anonymous concerns suggesting people were not always safe living at the home. In particular, care workers used inappropriate methods to support people with mobility. The concerns also stated one care worker was 'rough' with people using the service. During our inspection one relative told us about similar concerns they had regarding their family member's treatment by a specific care worker. We raised these concerns with the area manager and manager. They told us the family member had already made them aware of the concerns and they had taken action to investigate the matter. As a result disciplinary procedures had already commenced and were still on-going. Throughout our visits to the home we observed care workers supporting people with transfers. We saw care workers always used the correct equipment and procedures to help keep people as safe as possible. Falls were logged and action had been taken to help prevent future falls.

We discussed safety in the home with all of the care workers we spoke with. They told us they felt people were now safer than they were previously. One care worker commented, "(Safe) now yes. The company has invested so much more in providing staff training so that staff are as fully competent as possible." Another care worker said, "We try our hardest to look after them the best we can. They get well looked after."

In May 2016 we received anonymous concerns about a high turnover of staff because of unfavourable treatment. We asked care workers for their views about the current staffing levels. One care worker commented staffing levels were "good" now. They went on to say, "In July (2016) they were atrocious." Another care worker told us, "(Staffing levels were) low at first, but have now picked up." A third care worker said, "Much better than when I started. People can get more attention. We can spend time with people, we can interact with them. We have time to sit together with people." A fourth care worker told us, "We have the right amount of staff now."

Following a recruitment drive the new provider had increased staffing levels. The manager told us this had allowed for a more stable staff team with agency hours down to 11 each week. We spoke with the agency workers on the night shift. They told us they had received a formal handover when they started their shift. One agency worker told us they had regular hours at the home and worked two to three days each week. The manager told us a new dependency tool was being introduced in January 2017. This would allow for a more accurate measurement of whether staffing levels were appropriate. We observed care workers were visible around the home and responded quickly when people needed assistance. People and relatives did not raise any concerns about staffing levels in the home.

In August and November 2016 we received anonymous concerns about cleanliness and infection control in the home. In particular, that there were no domestic staff, there had been no cleaning materials for weeks and night staff were cleaning toilets with water only. Other concerns included care workers being instructed

to hoover and mop floors after midnight disturbing people's sleep and that 'bedrooms were filthy'. We asked care workers about their night time duties. They said if it was quiet they would sometimes carry out cleaning duties but only if people's needs had been met first. They confirmed there was no expectation for them to carry out these duties if it meant people would be left without support.

When we visited the home we observed cleanliness was to a good standard. We noted there was a clean and fresh odour all around the home. The provider had recruited two domestic staff with a third one due to start. We observed domestic staff were visible carrying out cleaning duties. This included deep cleaning people's rooms which involved cleaning carpets and curtains. We checked the supplies in the home and found there were plenty of cleaning materials available. Relatives and care workers told us cleanliness had improved since the new provider took over. One relative said they had concerns earlier in the year with cleanliness but had seen a "definite improvement". Another relative commented, "Cleanliness is much better, it was run down." One care worker said, "It is clean, you don't have any nasty smells when you come in."

Prior to the current provider taking over management of the home a safeguarding log had not been kept. When we visited the home in December 2016 this was now in place. There had been one safeguarding concern which had been dealt with in line with the expected procedure including a referral to the local authority safeguarding team and the required statutory notification to the CQC.

Care workers were aware of the provider's whistle blowing procedure. They told us they would report any concerns they had. One care worker commented, "I would definitely raise concerns. I haven't used it (whistle blowing)." Another care worker said, "I would report them (concerns) straightaway to the manager. I think she would be on top of things. I have no concerns. Everything I have seen has been fine." A third care worker told us, "I have not used it but I have no concerns about raising concerns. The manager is definitely really easy to talk to and would take things seriously."

The provider had in place effective recruitment check to ensure new care workers were suitable to work at the home. Pre-employment checks had been completed including requesting and receiving two references and Disclosure and Barring Service (DBS) checks. These checks were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with people.

There was a range of health and safety checks in place to help keep the premises and equipment safe to use. This included checks of fire safety, specialist equipment, the electrical installation, gas safety, water safety and portable appliance testing. These were up to date when we visited. There were also procedures in place to help ensure people were kept safe in an emergency situation and continued to receive the care they needed. We also observed maintenance men on site doing work to improve the environment in the home.

Requires Improvement

Is the service effective?

Our findings

In August 2016 we received anonymous concerns about the support people received with eating. In particular, that care workers did not encourage some people to eat their meals. People and relatives gave positive feedback about the improvements made with the meals provided at the home. One person told us, "I love the food, but like to eat in my room." One relative commented, "The food is changing for the better." We saw there were refreshments of squash and fruit available in communal areas so that people and relatives could help themselves whenever they wanted.

We observed over lunch time in both dining rooms to help us assess people's dining experience. We saw people received their meals shortly after they were seated in the dining room. We saw when people sat down they were offered a wet wipe to clean their hands before eating their meal. People were not offered a choice despite other options being available on the drinks trolley. For example, in the upstairs dining room all people were served with a drink of orange squash without care workers first checking that was their preference. In the other dining room most people were also given orange squash. One person was given their usual drink of non-alcoholic red wine and another person liked a glass of milk which they were given. However, again care workers did not routinely check that was what people wanted. We overheard people commenting they had enjoyed their meal. One person said, "Thank you I enjoyed that." Another person commented, "Oh wasn't that nice, that was lovely."

Care workers were usually attentive to people's needs over lunch-time. In the upstairs dining room care workers regularly checked whether people were able to manage independently and asked if they needed any assistance. One person wanted help cutting up their food which the care worker provided straightaway. We saw on a small number of occasions in the downstairs dining room care workers were not always attentive to people's needs. For example, one person was sat a long way from the table. A care worker gave the person soup but did not notice this. The person tried for quite a while to eat their soup until the deputy manager entered the dining room, immediately noticed and pushed the person's chair nearer to the table. This enabled the person to eat their lunch more successfully. Another person asked on four occasions for a spoon without care workers realizing. Where people did not want what was on the menu, an alternative was offered. For example, one person had scrambled eggs as an alternative. Another person who did not want dessert was offered fruit instead which they ate.

Where people required one to one assistance from care workers to eat and drink this was provided appropriately. We observed a care worker supporting one person to eat breakfast. Was saw they were very understanding and did not rush the person. Other people sat with the person were also very encouraging and were coaxing the person to eat.

Care workers told us they were well supported to carry out their role. One care worker told us, "I feel well supported. [Area manager] and [human resources] are very, very good, approachable. We have had support from managers from other homes." Another care worker commented, "I am very supported. If I have a question I can ask any of them. I can approach managers with questions." A third care worker said, "I am supported, [deputy manager] is amazing." Previously care workers did not receive regular one to one

supervision. Records confirmed the new provider had implemented supervisions and these were now taking place on a regular basis.

Training records confirmed care workers had received the training they needed in their role. This included infection control, food safety, fire safety, moving and handling and safeguarding. Care workers confirmed the provider supported and encouraged them to complete relevant training. One care worker commented there was "lots of training, usually in house". They said, "We have a very good trainer who is on the end of the phone if we need support on training." They also said they worked closely with Tyne and Wear Care Alliance around training.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us that when the provider took over management of the home DoLS authorisations had not been requested for all relevant people. All people had now been assessed and DoLS authorisations had been approved for 23 out of 35 people. This was following an MCA assessment and best interest decision having been made on behalf of each person. We saw other examples of MCA assessments and best interest decisions in people's care records in respect of their placement at the home, managing finances and where people could not consent to their care plans.

Care workers demonstrated they understood the MCA by describing how this applied to people using the service. One care worker described how they made meal choices for some people who lacked capacity. They said, "At lunchtime we sometimes make decisions for people based on what we have seen them eating before." Other care workers told us about how they showed people items of clothing to choose from based on what they knew of their preferences and life histories. They went on to tell us this information was available in people's care records for them to refer to. The provider was in the process of further developing care workers' knowledge of MCA as part of the comprehensive action plan for the home.

We observed care workers always asked for consent before offering or providing any assistance. For example, one care worker asked a person, "How do you fancy helping me make a cup of coffee." When the person said "yes", the care worker commented, "Come on then let's go." The person left with care worker, happily chatting.

Care workers described the strategies they used to support people when they were anxious or agitated, such as distraction techniques. One relative told us their family member had come into the home taking a specific medicine to help with behaviours that challenge. They said due to the care and support of care workers "they (family member) have now been weaned off this which we are very happy about".

Care records showed people had very regular input from a range of external health professionals. This included GPs, specialist nurses, district nurses and dietitians.

Good

Is the service caring?

Our findings

In May 2016 and August 2016 we received anonymous concerns about people not receiving the personal care they needed. In particular, people being ignored, people 'being left soaking wet in chairs for long periods of time'; care workers not showering and bathing people properly, people being refused showers and oral hygiene being neglected. We also received anonymous concerns about people's care from night staff. In particular, care workers were refusing to support one person to change into pyjamas for bed as they displayed behaviours that challenged. This meant they had to sleep in their clothes. Other concerns stated night care workers were expected to get people up and dressed before the day shift started.

We carried out an early morning inspection at 6am so we could speak with the night staff and look into the concerns raised. When we arrived at the home we found most people were in bed sleeping. There were six people up who all confirmed this was their choice and their usual morning routine. We spoke with the night time care workers who confirmed they had no concerns about people's care. One care worker told us, "We are meeting people's needs. There are no expectations about getting people up. We don't go around waking anybody up." Another care worker commented, "Now we get a chance to interact (with people), to dance and sing songs. The things that we should be doing. We are not just here to give personal care but to treat people as a human being." We checked up on the person mentioned in the anonymous concerns. They were still in bed when we arrived and were dressed appropriately for sleeping. One care worker commented, "I wouldn't let staff put [person] to bed in their clothes."

In August 2016 we received specific concerns about specific people using the service which we looked into as part of this inspection. For example, that care workers deliberately withheld a special possession from one person and another person's personal hygiene had been neglected. When we arrived at the home we observed this person was sitting in the communal lounge. We noted the person had their possession with them. Throughout our visit we observed many occasions where care workers prompted the person to pick up and hold their possession as it was special to them. We observed throughout our visits care workers responded appropriately to maintain people's personal hygiene. We also saw people were clean and dressed appropriately. For example, one care worker noticed one person had powder on their top. We heard the care worker say, "[Person] you have powder on your clothes. Can I get a damp cloth and wipe it off." After the person said "yes", the care worker left and returned quickly with the cloth. When another person said they were tired and wanted to have a sleep in their chair. We overheard a care worker saying, "Would you like a blanket." A blanket was then provided shortly afterwards.

People gave us positive views about their care. One person commented, "It is lovely in here, but I would like to go home". Another person told us, "I like it here, I like the people. I like everything about it." One relative commented they were "overall happy with the service." Relatives of another person visited as regular as they could and both said they "couldn't ask for better". They were happy their relative was "being cared for well".

People told us care workers were caring and considerate. One person said, "They (care workers) are good. They are nice people. They are always working hard, they look after you." Another person commented, "They are lovely girls." One relative was happy with the caring approach of the care workers. They said the

only problem was their relative received "too much love" from care workers. They went on to comment, "The girls are all lovely. The girls look after the family as well. I can't fault the girls at all."

Care workers showed a good understanding of people's needs. One relative told us care workers knew their family member's needs well. They commented, "They know [my family member's] needs, better than me sometimes."

Care workers described how they promoted dignity and respect whilst caring for people. They said they would talk to people when providing personal care, explain each step, ask for consent and respect people's right to refuse.

Care workers encouraged people to be as independent as possible. They told us they would always try to encourage people and give prompts. One care worker told us, "We make sure that if they can do it they get to do it to keep their independence." One care worker described how they supported one person in a particular way when helping them to bathe. This was because the person had certain difficulties. The support included filling the bath first and allowing the person to feel the water before getting into the bath. Once the person was settled they were given a facecloth to wash them self.

Requires Improvement

Is the service responsive?

Our findings

In August and November 2016 we received anonymous concerns about care records lacking meaningful information about people's needs. In particular, one person's moving and handling needs had not been assessed and care plans lacked relevant information about the care people required. When we inspected we found these concerns were accurate. We viewed care records for five people and found they all contained inaccurate and incomplete information. This placed people at an increased risk of receiving care that did not reflect their current needs.

We found one person had particular difficulties with pain management and had a specific medical condition. We found although care plans had been written they were very brief and lacked sufficient detail about how care workers should care for the person's needs. For example, the care plan described the medicines the person had been prescribed to help with breakthrough pain. However, there was no information to guide care staff when to administer such as the triggers to look out for. The person's 'personal hygiene' care plan stated the person required two carer workers to assist them with washing and dressing. The care plan did describe what actual support the person needed from care staff. The care plan had been evaluated monthly but contained contradictory information. For example, the last evaluation carried out in November 2016 stated '[person] requires two staff to assist but usually only requires one.'

Another person's communication assessment stated they 'had difficulty speaking'. The person's care plan did not describe what difficulties the person experienced. The plan also did not describe the most effective strategies for care workers to use to communicate with the person to enable them to make as many of their own decisions and choices as possible.

A third person had been assessed as being at 'medium risk' of skin damage. The person's skin integrity care plan, written on 26 November 2016, stated '[Person's] skin is dry. Staff to put zero-base moisturising cream on which is found in the en-suite.' We asked to view the associated records for the application of creams. The senior care worker advised us the person did not have problems with their skin and did not require creams to be applied. The care worker who had written the care plan told us they made a mistake as the person used to have zero-base but not anymore. They went on to say the person's relatives applied ointment each day. This had not been documented in the person's care plan.

A fourth person had initially been admitted to the home for respite. The manager told us the person was now living permanently in the home. The person's care plans were the original respite care plans which contained only basic information. There had been no detailed care plans written to reflect the person's change if circumstances.

We observed one occasion when care workers did not follow a person's care plan. The person's care plan stated the person could become agitated when the lounge was full or noisy. We saw at one point during an activity the person was agitated and shouting that the music was too loud. Care workers did provide re-assurance but did not support the person from the lounge to a quiet area as directed in their care plan.

Care plan evaluation records were brief and consisted of general statements rather than a meaningful update as to the relevance of the person's care plan or the person's needs. For example, evaluations contained statements such as 'no change to this month's care plan'. This meant it was difficult to assess whether people's care plans were relevant to their current needs.

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

The new manager told us they had been working on a model care plan with a competent senior. This was to be used as a reference point for other care workers to guide them as to the provider's expected standard. The new manager stated this was the only care plan in the home that had been written to an acceptable standard. We viewed this care plan and saw it was detailed and personalised. All relevant care staff were enrolled onto a bespoke care plan training course.

Care workers were responsive to people's needs and requests for help. For example, one relative told us about a time when they had highlighted that their family member did not have grab rails in their bathroom for support. They said, "Within a couple of days these were in place." We overheard a person talking to a care worker in the lounge. The care worker told the person they would arrange to get their clothes washed that evening as they were aware the person had a preference for that particular outfit. One relative commented, "[My family member] was poorly in June. I was informed straightaway."

The home had employed a new activity co-ordinator. They discussed with us their plans for developing activities in the home. They said people had started attending a local singing group specifically for people living with dementia. They were also developing links with the local community. Visits had been arranged for children from a local school to visit the home. They were also meeting with the local vicar on the day of our visit to discuss Christmas activities. The activity co-ordinator told us they were looking to enrol on a specific meaningful activity training course in the new year. People had personalised activity records which showed the activities they had taken part in. For example, in November one person had taken part in quizzes, sing a longs, watching films, arts and crafts and a manicure.

Activities were on-going during our visit to the home. The activities co-ordinator engaged people in an exercise based game using a large colourful soft ball. This involved the activity co-ordinator throwing the ball to people who then caught the ball and passed it back. Bingo had been planned for later in the day.

We did not observe any activities taking place on the ground floor. The television was on in the downstairs lounge with music also playing in the back ground. One area of the home had been set up to look like a pub with a juke box and pool table. We observed people had unrestricted access to the area. We saw people going into the room to listen to music and play pool. Relatives were able visit the home whenever they liked. One person had been to the coast that morning with a relative. Another relative had visited earlier with a pet dog.

Two complaints had been made within the last 12 months. These were both related to issues from when the previous provider was managing the home. These had been fully investigated and resolved in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

The provider did not keep accurate records to evidence the care people needed to keep them safe and maintain their wellbeing. All care records we viewed including fluid balance charts, topical medicines application charts (TMARs) and MARs were either inaccurate, incomplete or not kept. We viewed fluid balance charts for five people and found they all contained gaps in recording. None of the charts had daily targets to guide care workers about how much fluids the person required each day. We also found none of the fluid charts had been totalled or analysed to check people were appropriately hydrated.

One person had a particular medical condition which meant they had to drink a certain amount of fluids each day. The person's care plan stated '[person] requires a well-balanced diet and plenty of fluids i.e. 2 litres per day'. The care plan went on to state 'staff to implement fluid charts daily to record the correct amount of fluid intake.' We asked a senior care worker for copies of these records. They told us there were no fluid charts but said they would put one in place straightaway. They also said they usually recorded in the person's daily records whether they had a good food and fluid intake that day. However, it was not possible to confirm from these records how much fluid they had consumed each day and whether they had met their daily target of two litres. The person's nutritional assessment had not been completed fully. There were also gaps in another person's fluid records. The person had been assessed as being at risk of poor fluid intake. For example, no records were available for the period 9 November 2016 to 4 December 2016.

Another person's care plan stated the person required care workers to monitor their mental wellbeing and document any incidences of behaviours that challenge on an 'ABC chart'. We asked the provider to view these charts, however none were available. This meant the provider was unable to provide evidence the person's wellbeing had been monitored appropriately.

We viewed TMARs for two people and found they did not accurately account for the creams care workers had applied to people's skin. For example, one person's TMAR stated 'apply at least 2 x per day.' However, there were no records available of when the cream had been applied. The person had another cream for which the TMAR stated 'apply 3 x daily'. Records viewed from 20 October 2016 to 6 December 2016 showed no record of application for the cream for 31 days out of 48, one application on 15 days and two applications on two days. There was no record showing three applications of the cream in line with the prescriber's direction. This meant we could not be sure people received the skin care they needed.

Care plan audits were ineffective and had had failed to deliver sustained improvements in the quality of people's care records. The inaccurate care records we viewed had all been audited. Some of the issues we identified during this inspection had not been identified such as the poor recording of people's fluid intake. Other concerns had been highlighted but no action had been taken to rectify the issues. For example, a care plan audit carried out in August 2016 identified one person did not have all the care plans they needed to meet their needs. When we checked the person's care records the care plans were still not in place.

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

In May, August and November 2016 we received anonymous concerns relating to the management of the home. In particular, negative comments about the management style of the previous manager, that there was a lack of leadership in the home, management disregarding concerns raised by care workers and care workers referring to people using disrespectful language during handovers. In May 2016 concerns were also raised about inaccurate record keeping, such as care workers giving false accounts of people's food and drink intake on food and fluid charts. They went on to state care workers had raised concerns but had left due to 'being bullied'.

We observed the morning handover meeting. Care workers who were due to go on shift attended the meeting, along with a night time care worker, the deputy manager and new manager. During the meeting there was a professional approach adopted by attendees. The night time care worker provided a summary of people's needs and how each person had been overnight including any people who needed additional monitoring or support.

The relatives we spoke with commented they had seen a lot of improvements this year. One relative said there had been a meeting in November 2016 to discuss the improvement plans for the home. One care worker commented, "It has changed a lot since the last manager. The home is much better now. It wasn't very well decorated and the carpets weren't very clean." Another care worker said, "[New provider] has done the rotas properly, sorted care plans and the home is cleaner. They have made us a full team again. There is not as much agency workers now."

The home had a new manager in post following the dismissal of the previous manager. They had applied to the CQC to become the registered manager for the home. Care workers told us the new manager was approachable and supportive. One care worker said, "If you have concerns you can go and see them (manager and deputy manager) anytime." Care workers also said there was now a good atmosphere in the home. One care worker said, "The atmosphere is quite good, a lot more relaxed than when I first came over here."

When the new provider took over management of the home they contacted the CQC to advise us a planned improvement plan was to be brought forward due to the poor standards they had inherited within the home and to deliver improvements to the care people received. The improvement plan was comprehensive and covered all aspects of people's care. We reviewed the progress the provider had made against this plan during this inspection. We saw progress was being made against all of the actions with a significant number already having been completed. For example, actions to ensure all relevant people had the appropriate MCA assessments and best interest decisions, all staff had completed essential training, recruiting additional care staff and domestic staff and the appointment of a new manager. Other actions were still on-going at the time of our inspection including a full review of care plans, continuing to recruit additional care workers and ancillary staff and a rolling programme of cleaning carpets and flooring in people's bedrooms.

Following our inspection the comprehensive action plan was updated to reflect the findings of this inspection. The provider sent us a copy of the revised plan and agreed to provide us with a weekly progress report until all actions have been completed. This will allow us the opportunity to closely monitor future progress and ensure the required improvements are delivered. The revised action plan confirmed further actions had been completed since the inspection to address some of the concerns we found. For example, all senior care staff had completed specific care plan training. All care plans were in the process of being written and checked for quality and accuracy with an expected completion date of February 2017. Other actions were on-going to improve the accuracy of care records and the effectiveness of care plan audits.

The provider classified the home as a focus home. This means the home was and continues to be closely

monitored and the home's action plan updated and checked by senior managers weekly. The provider advised us that after the inspection the home would continue to be a focus home until a joint decision was made by senior management agreeing expected standards had been achieved and could be sustained.

The provider was implementing other checks on the quality of people's care which were still being developed when we visited. These included a monthly manager's night audit, a daily walk around and flash meetings throughout the day. The provider was also introducing a scheme known as 'resident of the day'. This was still being embedded when we inspected. This would provide a focus on the care of a particular person to ensure they were receiving the care they needed. This included a check on every aspect of the person's care including care records, a deep clean of their room, maintenance checks, reviewing preferences and a visit from the cook to update dietary information.

People and relatives had opportunities to share their views about the home and the quality of the care provided. People had been consulted to gather their views about the care they received at the home. In August 2016 two separate consultation exercises had been carried out asking people for their views relating to dignity and respect and the quality of food. We viewed the feedback received from 12 people and found people were happy in these areas. For example, all people confirmed they were treated with dignity and respect and were encouraged to make independent choices. Meetings were held with people and relatives. One relative told us they had the opportunity to attend meetings.

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 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 provider failed to adequately assess and mitigate risks to the health and safety of people using the service because risk assessments and associated care records were inaccurate or incomplete. Records did not support the safe and proper management of medicines. Regulation 12(2)(a), 12(2)(b) and 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to adequately monitor the quality of people's care plans and accurately assess the risks relating to the health, welfare and safety of people using the service. The provider did not maintain accurate records of the care each person had received. Regulation 17(2)(a), 17(2)(b) and 17(2)(c).