Care Quality Commission

# Ainsworth Nursing Home Limited

# Ainsworth Nursing Home

## Inspection report

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## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Inadequate |

## Overall summary

This was an unannounced inspection which took place on 12 November 2014. The service was last inspected in February 2014 when we found it to be meeting all the regulations we reviewed.

Ainsworth Nursing Home provides accommodation for up to 37 people who have nursing or personal care needs. There is a dedicated unit for people with dementia care needs. There were 33 people living in the home at the time of our inspection, 16 of whom were living in the unit for people with dementia care needs.

The service had a registered manager in place. 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 and associated Regulations about how the service is run.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

We were told by staff, people who used the service and relatives that there was a general lack of staff on the unit for people with a dementia. This was confirmed by our observations on the day of our inspection when we found staffing levels were insufficient to ensure people's needs were met in a safe and appropriate manner. In addition, people on the general nursing unit did not receive their medicines as prescribed on the morning of our inspection due to a lack of nursing staff available to administer those medicines.

The systems to ensure the safe administration of medicines in the service were not sufficiently robust to ensure people who used the service were adequately protected.

All the people we spoke with who were able to express a view told us they felt safe living in Ainsworth Nursing Home. Relatives we spoke with were mostly confident that their family member was safe in the service. However, one relative was concerned about a recent fall experienced by their family member.

Staff had received some training in how to protect people who used the service from the risk of abuse. Staff were able to tell us of the correct procedure to follow should they have any concerns about the safety of a person who used the service. Staff were confident to report poor practice in the service and we found evidence that the whistleblowing policy for the service was effective.

Staff told us they enjoyed working at Ainsworth Nursing Home and considered they received the training and support they needed to effectively carry out their role. However, we found only senior staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS); these provide legal frameworks to ensure people's rights are upheld. As a result of this lack of training care staff we spoke with showed a lack of understanding about the need to ensure inappropriate restrictions were not placed on people.

We found staff had not received adequate training or guidance in how to support people whose behaviour might challenge others. This meant there was a risk that people who used the service might be subject to unnecessary or inappropriate methods of restraint by staff.

We could not be confident from the records we reviewed that there was sufficient monitoring of people's nutritional needs. Improvements needed to be made to ensure people who used the service could have access to drinks at times of their choice.

While people who used the service and relatives gave positive feedback about the attitude and approach of staff, on the day of our inspection we saw that not all staff interacted with people who used the service in a way which demonstrated care and compassion.

People who used the service told us they received care and support which met their needs. However, we found the information in care records needed to be improved in order to ensure people always received consistent care.

The service employed an activities coordinator. However, on the day of our inspection we observed there was a lack of meaningful activities for people who used the service. Although people who used the service did not make any comments about the activities available for them, relatives we spoke with told us they felt the level of activities provided in the service could be improved.

There were systems in place for people who used the service and their relatives to comment on the service provided at Ainsworth Nursing Home. All the people we spoke with told us they would be confident to raise any concerns with the registered manager.

Improvements needed to be made to the quality assurance systems in the service. Internal audits had not been completed for over three months. This meant there was a risk that the registered manager would not be able to identify where improvements needed to be made in order to ensure people who used the service always received safe and appropriate care.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Inadequate**

Some aspects of the service were not safe.

People who used the service told us they had no concerns about their safety in Ainsworth Nursing Home. Staff had received training in how to protect people from abuse and were clear about how to respond to any allegations of abuse

Recruitment processes were mostly safe although improvements needed to be made to ensure all nurses employed in the service were registered with the Nursing and Midwifery Council.

Staffing levels were insufficient to ensure people always received safe and appropriate care.

People were not adequately protected by the systems in place to manage medicines.

**Is the service effective?**

**Inadequate**

The service was not always effectively meeting people's needs.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves. Not all staff had received training to help them to understand their responsibilities under the MCA and DoLS.

Care plans did not include sufficient information for staff about how they should respond to people whose behaviour might challenge others. This meant there was a risk that inappropriate methods of physical intervention might be used by staff.

Improvements needed to be made to the way people's nutritional needs were monitored and met.

**Is the service caring?**

**Requires Improvement**

The service was not always caring. People who used the service told us staff were kind and caring. Relatives we spoke with also gave positive feedback about staff.

Although we observed positive interactions between some staff and people who used the service, there were other occasions when we saw other staff did not treat people with compassion, kindness or respect.

There was a lack of evidence that, as much as possible, people who used the service were involved in making decisions about their care.

**Is the service responsive?**

**Requires Improvement**

The service was not always responsive to people's needs.

# Summary of findings

We found improvements needed to be made to ensure that people always received the care they needed.

People told us they were happy that the care they received met their needs. However, care records did not always provide sufficient information to ensure staff knew how to appropriately respond to people's needs.

There was a lack of meaningful activities for people.

**Is the service well-led?**

Inadequate 

The service was not well led.

This was because the quality monitoring systems at Ainsworth Nursing Home were not sufficiently robust to ensure people who used the service were protected against the risks of unsafe or inappropriate care.

The home had a manager who was registered with the Care Quality Commission and was qualified to undertake the role.

Staff told us they enjoyed working at Ainsworth Nursing Home and felt well supported by the registered manager and senior staff.

# Ainsworth Nursing Home

**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 checked 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.

The inspection took place on 12 November 2014 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor in the care of people with a dementia 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. The expert had experience of residential and nursing care services.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We also contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain their views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

All the organisations we contacted stated they had no comments or concerns about Ainsworth Nursing Home. We were aware from information previously received from the local authority safeguarding team that there had been a safeguarding investigation at the service in the previous six months which had resulted in disciplinary action being taken by the provider.

We spoke with seven people who used the service and six relatives. We also spoke with eight staff and the registered manager.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observation Framework for Inspection [SOFI] observation during the lunchtime period on the general nursing unit of the home. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for 11 people who used the service and medication records for a further 13 people. We also looked at a range of records relating to how the service was managed; these included training records, quality assurance systems and policies and procedures.

Inadequate

# Is the service safe?

## Our findings

People who used the service, who were able to express a view, told us they felt safe in Ainsworth Nursing Home. This view was confirmed by five of the six relatives we spoke with. Comments people made to us included, "Yes I feel safe here, I don't worry about anything", "I feel safe, I never think about it.", "Yes, all the doors are locked" and "I did, but [my relative] fell the other day, I felt [my relative] was safe until then."

On the day of our inspection we had concerns about the staffing levels in the home. We found the nurse who usually worked on the general nursing unit was on training. The registered manager told us they had intended to cover the nurse's duties but had been unable to do so as a result of the inspection. However, the registered manager did not inform the inspection team of the need for them to be available to prioritise this task. Following our discussions they arranged for the deputy manager to attend work to provide additional nursing cover. We noted they arrived on shift towards the end of the morning.

We asked the registered manager about systems in place to assess the dependency levels of people who used the service in order to ensure there were sufficient numbers of staff on duty to meet their needs. The registered manager told us there was no dependency level assessment tool in place and the provider expected them to meet the needs of people within current resources.

Staff we spoke with on the general nursing unit told us there were usually enough staff on duty to meet people's needs. However, staff working with people with dementia needs told us there was a lack of staff on this unit and as a result they were under pressure in trying to meet people's needs. People who used the service and relatives we spoke with also told us there were not always enough staff on duty. One person who used the service commented, "We are short of nurses, we help them as much as we can." One relative told us "Staffing is a bit of a worry at meal and toilet times due to lack of staff. They've not got three permanent staff; it's always a bit lacking in staff."

As a result of there being no nurse available on the general nursing unit we found, from reviewing the medication administration record (MAR) charts, that at 11am no one on that unit had received those medicines which were prescribed to be administered at breakfast time. Also we had previously heard a person request pain relief medication from a member of staff but it was clear, from the records we reviewed, that this had not been given. This meant people's health was at risk because they had not received their medicines as prescribed. There was also a risk that people were left in pain unnecessarily. We discussed this with the registered manager who told us the nurse on duty in the dementia unit would be administering the medicines to people in the general nursing unit as soon as possible.

The lack of sufficient staff to meet people's needs is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the arrangements in place for the administration of medicines. We found the MAR charts we looked at on the unit for people with dementia needs were correctly completed and up to date. Appropriate arrangements were in place for the storage and administration of controlled drugs.

People we spoke with who used the service told us they received their medicines as prescribed. However one relative expressed concern to us that their family member did not always receive the pain relief medicines she needed.

During our inspection we noted medicine prescribed for one person had been left in a container with other items on the workstation located at the entrance to the service. We noted this medicine was prescribed to be taken four times a day after food. However, the MAR chart showed that the medicine had only been given three times a day since it was prescribed. In addition the medicine had not been administered on two occasions prior to our inspection. We asked both the registered manager and the nurse on duty why the medicine had been left on the workstation and why it had not been given as prescribed. Neither member of staff was able to provide an explanation for this. This meant the person's health was at risk because they had not received their medicines as prescribed.

We noted nursing staff were required to check and record the temperature of the fridge used to store medicines. However we found these checks had not been completed for three days prior to our inspection. This meant there was a risk medicines were not stored at the correct temperature and might therefore be ineffective.

Inadequate

# Is the service safe?

We spoke with a nurse and the deputy manager about any checks which were in place to assess their ability to safely administer medicines. The deputy manager told us no such checks had been carried out during the 12 years of her employment at the service. The nurse we spoke with had only recently been employed at the home but confirmed that no checks of their competence to safely administer medicines had been completed since her employment commenced. The lack of a system to regularly check that staff had the necessary skills and knowledge to safely administer medicines meant people who used the service might be put at risk.

We asked the registered manager about any systems in place to monitor the effectiveness of the arrangements for the administration of medicines in the service. They told us no medication audits had taken place for some time. This meant they could not be certain that people were adequately protected against the risks of the unsafe administration of medicines.

The lack of appropriate systems to ensure the safe management of medicines in the service is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records we looked at confirmed 30 out of a total of 33 staff had completed safeguarding training. All the staff we spoke with confirmed they had completed this training. One person who recently started working at the home told us they had undertaken safeguarding training at a previous place of employment in a different local authority. However, they were aware of the location of the safeguarding policy for the service and procedure for reporting abuse to the local safeguarding team.

All except one staff member we spoke with told us they were aware of the whistle blowing (reporting poor practice) policy in place at Ainsworth Nursing Home. All the staff we spoke with told us they would be confident to report poor practice in the home and were confident they would be listened to.

On the day of our inspection the registered manager made us aware that they had raised a safeguarding alert with the local authority as a result of concerns raised by staff about a colleague's interventions with a person who used the service. This demonstrated the whistle blowing procedures in the home were effective and staff understood their responsibility to protect people who used the service from unsafe or inappropriate care.

We looked at files for three staff employed at Ainsworth Nursing Home. We noted robust recruitment processes were in place for care staff, including pre-employment checks. However we found there was no system in place to ensure that nursing staff employed in the service were registered with the Nursing and Midwifery Council. This meant there was a risk that people might receive care and treatment from unregistered staff.

Care plans we looked at had an assessment of people's needs and a plan of care which included risk assessments. While most risk assessments were fully completed and reviewed on a regular basis, we noted the care file for a person who had recently been admitted included a risk assessment which highlighted the person had swallowing difficulties. However, we found the risk management plan did not include the action staff should take to avoid the person choking. This meant there was a risk the person might receive unsafe care.

During our inspection we noted care records for people who used the service were kept in an unlocked cupboard under the workstation which was located at the entrance to the service. This meant inadequate arrangements were in place to ensure the safety and confidentiality of people's personal information. We discussed this with the registered manager who told us they would make arrangements for a lock to be fitted to the cupboard as a matter of urgency.

We asked the registered manager about any systems in place to monitor the effectiveness of the arrangements for the administration of medicines in the service. They told us no medication audits had taken place for some time. This meant they could not be certain that people were adequately protected against the risks of the unsafe administration of medicines.

The lack of appropriate systems to ensure the safe management of medicines in the service is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted staff on the unit for people with dementia related needs might be at risk if they needed to summon assistance from others in the event of an emergency. This was because the alarm system for the unit did not sound in

Inadequate

# Is the service safe?

other parts of the home. We discussed this with the registered manager who told us they would review how this situation could be improved for the safety of staff and people who used the service.

Records we reviewed showed a fire risk assessment was in place for the service. Staff had also received training in fire safety. This should help ensure they knew what action they should take in the event of an emergency.

Following the inspection we were sent minutes of staff meetings which had not been available at the inspection. We noted staff had been asked to discuss how they would respond to both safeguarding and fire safety incidents. This should help ensure staff understood what action they should take to protect people who used the service.

Inadequate

# Is the service effective?

## Our findings

People who used the service told us staff provided them with the care they needed. They told us staff seemed to know them well.

We asked the relatives we spoke with if they considered staff had the skills and knowledge they needed to provide effective care to people. Replies from relatives included, "Yes I do, they [staff] go on training courses", "That's difficult, some do", "The ones I've seem to know exactly what they're doing" and "I guess so, [named staff member] knows about [my relative's]condition."

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection there were seven people for whom applications to restrict their liberty had been authorised by the local authority. The registered manager told us they were aware of recent changes to the law regarding when people might be considered as deprived of their liberty in a residential or nursing care setting. They told us they were in regular contact with the DoLS team at the local authority to ensure the required applications were submitted should any restrictions need to be in place for people to ensure they received the care they required.

Records we looked at showed only senior staff had completed training in the MCA and DoLS. The registered manager told us this was because this training was only available to senior staff from the local authority. No consideration had been given as to how relevant information might be cascaded to other levels of staff in the service by those who had received the training. As a result we found a lack of awareness from some of the staff we spoke with regarding the legally authorised restrictions which were in place for some people.

At the start of our inspection we noted a sign on a door which stated that people who used the service were only permitted to smoke cigarettes at certain times of the day. During the inspection a staff member approached us asking for the manager and commented "I just want to know if it is time for me to let [people who use the service] out for a cigarette". This staff member was new to the service.

We noted a diary we looked at contained the comment '[person who uses the service] has been smoking in [their] room, lighter taken off [them]'. We also found two people had their cigarettes and lighters kept in the manager's office and had to ask for these. The manager told us the people concerned had consented to these restrictions being in place. However, when we looked at the care records for one of the people concerned we could not find any evidence that their capacity to consent to this arrangement had been assessed. There was also no care plan in place to provide guidance for staff about how the person should be supported to smoke safely.

During our inspection we noted several occasions on which staff failed to offer any choice to people who used the service; these included giving people drinks without checking what they wanted, moving people in wheelchairs without checking where they wanted to be moved to or explaining why the staff member was moving them. We also noted that on one occasion a person's request for assistance to move away from the dining table was refused by a staff member and another person was told they could not have anything else to drink until they had finished what was in their cup. This demonstrated a lack of respect for people's ability to make their own decisions.

The lack of evidence that staff sought and acted in accordance with the consent of people who used the service or assessed people's capacity to make particular decisions before any restrictions were put in place is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with told us they had received training in a range of topics relevant to their role including nationally recognised qualifications. We saw the registered manager had a training plan in place which was submitted to the local authority in order for appropriate courses to be arranged. However we found this reliance on the local authority to provide all training meant there was a lack of flexibility in how the training needs of staff were met.

We spoke with a member of staff who had been recently employed by the service. They told us they had received an induction when they started work at Ainsworth Nursing Home and considered this had prepared them well for their role.

Staff working on the unit for people with dementia related needs had completed some training on providing dementia care. However, none of the staff we spoke with had received training on how to care for people whose

behaviour might challenge others. This meant staff gave inconsistent responses when we asked them how they would respond if a person became agitated or distressed. One staff member told us "sometimes [people who use the service] kick and hit out at me when they are sat in their chair, so I hold their knees to stop them from kicking me". Senior members of staff told us that should a person become distressed or aggressive they would try and calm the person or distract them. Care plans we reviewed did not provide any guidance for staff to follow should a person be known to display behaviour which might challenge others. This meant there was a risk people who used the service might not receive effective care due to the use of inappropriate restraint.

We saw there were systems in place to monitor people's nutritional needs. However, when we looked at the care records for one person who had been admitted to the service from hospital where they had been treated for malnutrition, we found weight monitoring records had only been completed for the first four weeks of their admission. The records showed that no further monitoring had taken place for four weeks, even though the person concerned had only gained 1kg in weight when this was last recorded. We also noted the chart used to record the food and drink consumed by another person who had identified nutritional needs had not been completed during our inspection. This meant we could not be certain if the people's nutritional needs were being adequately met.

The lack of guidance in care plans to inform staff of the action they should take to meet people's needs effectively and the inadequate recording and monitoring of people's nutritional needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we observed one person who used the service ask a staff member for a hot drink. However, they were told they would have to wait for the drinks trolley to be brought to the unit. We noted there were no jugs of water or juice available for people to access drinks independently where they were able to do so. Fresh fruit was also not readily available for people. We discussed this with the person responsible for planning and preparing food in the service. They told us they would always make drinks or snacks if people who used the service requested this. They told us people on the general nursing unit would readily approach them at the kitchen if they wanted anything. However, we noted people who were cared for on the unit for those with dementia related care needs would not be able to access the kitchen should they wish to do so due to the locked nature of the unit.

We noted there was no information on display in either of the units regarding the choice of meals available to people who used the service. The person responsible for preparing the meals on the day of the inspection told us they were always flexible in providing alternative meals for people if they did not like the choices on the menu. One person we spoke with who used the service spoke positively about the food provided but told us "you either eat it or leave it unless you ask in advance (for an alternative)."

During our observation at lunchtime on the general nursing unit we noted meals were brought uncovered to the unit on a trolley from the central kitchen some distance away. This was unhygienic and meant there was a risk meals would be cold by the time they reached people who used the service.

People who used the service told us staff would always contact their GP if they were unwell. We saw evidence that staff had made referrals to other health professionals including the tissue viability nurse and speech and language therapist if they had any concerns about a person's health.

People who used the service did not express any concerns about the environment of the home. Relatives we spoke with about the environment expressed varying views. Comments they made to us included, "It's fine", "The outside needs sprucing up, they do their best", "Excellent, but they could do with opening more windows" and "I call it shabby chic, they could do with more facilities, they probably need more showers." We observed another relative expressed concerns to the registered manager regarding the lack of light in their family member's room but they were told another room was unfortunately unavailable.

We noted some areas of the home, particularly the conservatory on the general nursing unit, smelled strongly of urine. The registered manager told us there was already a plan in place to replace the carpet in this conservatory.

We noted there was a lack of appropriate signage on the unit in which people with a dementia were cared for. This included a lack of pictorial signs to identify toilet and bathroom facilities as well as a lack of photographs or

Inadequate

# Is the service effective?

other identifying features on some bedroom doors. The use of pictures and other visual aids can be helpful in promoting the independence and orientation of people with dementia related needs.

Requires Improvement

# Is the service caring?

## Our findings

People we spoke with who used the service spoke positively about staff. When asked if staff were kind to them people commented, " Very kind in lots of ways; they respond before you are aware there is a problem", "Well, I suppose so" and "Yes, very kind and very thoughtful." People who used the service told us staff treated them with respect by addressing them by name and always speaking to them politely. They said staff always preserved their dignity when providing any personal care. Relatives we spoke with also gave positive feedback about staff.

During the inspection we observed some positive interactions between staff and people who used the service. We observed staff knock before they entered the room of a person who used the service and respect the person's wishes to remain in bed until later. We also observed a member of care staff respond to a person who was rubbing their knee to check if they were in pain and advise the person they would contact the nurse in charge for further checks to be undertaken.

However, we noted many of the bedroom doors on the general nursing unit were left open while people remained in bed and asleep. This meant there was a risk that people's dignity and privacy was not respected. We asked the registered manager how they ensured people had the privacy they needed and wanted. The registered manager acknowledged people's preferences regarding bedroom door closures should be sought and recorded on care plans.

We observed two occasions in which a large group of staff were sat around the table in one of the lounges whilst taking their break. We were told staff used the resident's lounge for break times as there was no staff room available for them to use. We noted there was no interaction between staff and people who were using the lounge at the same time. This demonstrated a lack of respect for people who used the service. We discussed this practice with the registered manager who told us they would raise the matter with all staff.

At another time during the inspection we observed one member of staff left a person who used the service whilst they were in the process of assisting the person to move to a comfortable chair in the lounge by use of a piece of hoisting equipment. This was in order to respond to shouts from the deputy manager in the corridor off the lounge. We observed the staff member concerned to respond by shouting, "We can't be in two places at once." Whilst it was only for a short period of time, the staff member concerned did not provide any explanation or reassurance to the person who used the service during the incident. Whilst the person receiving care did not raise any objections or appear distressed by the incident, this demonstrated a lack of care and respect on the part of the staff member concerned.

During our observations in the general nursing unit at lunchtime we noted poor practice when one staff member interacted with a person who used the service. This involved the staff member concerned responding in an abrupt and disrespectful manner when the person who used the service told them they could not eat the meal which had been served to them. Although the staff member did eventually provide an alternative meal which the person was happy to eat, they did so in a way which failed to acknowledge the person's need for care and support. We raised our concerns about the staff member's attitude with the registered manager. They told us they would address the concerns as a matter of urgency.

We asked the registered manager how people were involved in making decisions about their own care. They told us nursing staff were responsible for completing regular reviews with people who used the service and their family members where this was appropriate. However, we did not see any evidence of involvement from the person who used the service or their relatives in the care records we reviewed. This meant there was a risk people might receive inappropriate care.

The lack of respect shown to some people who used the service and the lack of evidence that people were involved in deciding how their care should be provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

# Is the service responsive?

## Our findings

Care records we looked at showed people's needs were assessed by the registered manager before they were admitted to Ainsworth Nursing Home. However, the assessment for one person who had been recently admitted to the service lacked detail. This meant there was a risk might not be fully aware of the care the person required.

Care plans we looked at mostly contained good information about people's care needs and the support they needed from staff. However, the care record for one person contained limited information about what staff needed to do in order to ensure the person received appropriate pressure relief. The moving and handling risk assessment indicated the person was at high risk of experiencing pressure sores and required 'assistance from staff to positionally turn during the day and at night'. However, there was no indication of the frequency at which staff should assist the person to move. During the inspection we noted this person remained in the same position for over 3 hours. We asked four staff about the frequency at which the person should be repositioned and were given answers which varied from two to four hours. This lack of clarity about how the person's needs should be met meant there was a risk staff were not responding appropriately to ensure people received safe and appropriate care.

We noted there was a lack of meaningful activities in the service on the day of the inspection. Two of the relatives we spoke with told us they considered there should be more activities provided for people who used the service.

We spoke with the activities coordinator employed by the service. They told us they generally focused their attention on the general nursing unit as they considered people who were living in the dementia unit were not interested in activities. We did not see any evidence that anyone using the service had been asked about activities they would like to be provided. The activity coordinator told us they would like to provide more activities for people but were restricted due to a lack of resources. They also told us they would like more training in how to provide appropriate activities for people with a dementia. We discussed this with the registered manager who told us the staff member had already attended some training but they agreed to discuss this further with them.

We saw a copy of the complaints procedure was displayed in the reception area of the service. We asked the registered manager how they dealt with and recorded any concerns people who used the service or their relatives might make. We were told there was an 'open and transparent' policy in the service and that this meant the registered manager was able to quickly resolve any complaints. However, we were told there was no means of logging any concerns or complaints raised by people to demonstrate the action which the registered manager had taken. This meant there was a risk that the service did not review and learn from feedback received.

People we spoke with who used the service told us they would feel confident to raise any concerns with the registered manager. We were told regular meetings took place between people who used the service and their relatives. Records we were sent following the inspection confirmed the last meeting had taken place in October 2014.

We asked the relatives we spoke with about any opportunities they had to comment on the service provided at Ainsworth Nursing Home. Comments people made to us included, "We had a meeting a few weeks ago and we got new chairs in the lounge very quickly", "I've been to a meeting but I don't recollect filling in a questionnaire" and "I'm sure I've filled a questionnaire in but not in the last 6 months." The registered manager told us the most recent satisfaction survey had been sent out in May 2014 but only one response had been received.

Inadequate

# Is the service well-led?

## Our findings

The provider had a registered manager in post as required by their registration with CQC. However we found they were not effective in reviewing and monitoring the quality of the service provided at Ainsworth Nursing Home.

We asked people who used the service if they felt able to approach the registered manager if they had any concerns. Comments people made included, "Yes I do, I'm not afraid of them [the registered manager" and "I think so." One person told us, "You have to approach them [the registered manager with care" but did not elaborate further on this comment when we asked them to do so.

We asked relative we spoke with if they felt they could talk to the registered manager. Comments people made to us included, "Yes, definitely. [The registered manager] put me at my ease straight away", "Questions are always answered promptly" and "I have a good relationship with the management and the staff."

All the staff we spoke with told us they were always able to approach senior staff for advice and support.

We asked the registered manager to tell us about the quality assurance systems which were in place in the service. They told us that the system of internal audits had not been completed for several months. This was because they had been struggling to cope without a deputy manager in place until four weeks prior to our inspection.

We looked at the weekly audit file. This was the means by which the registered manager recorded and monitored accidents and incidents in the home, complaints, hospital admissions relating to people who used the service and staff recruitment and induction details. We saw this had not been completed since 28 July 2014. This meant there was a risk that the registered manager would be unable to identify where improvements needed to be made to the service people received.

We found there was no system in place to monitor the quality and effectiveness of care plans to ensure that people received safe and appropriate care. The lack of such a system was reflected in our findings regarding some of the care records we reviewed.

The lack of robust quality assurance systems in the service is a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

We saw that the registered manager was regularly submitting quality assurance data to the NHS. This included a 'Safety Thermometer' which recorded the number of falls and pressure ulcers experienced by people in Ainsworth Nursing Home. This meant there was some limited external monitoring of the effectiveness of the service provided at the home.

Records we looked at showed recent meetings had taken place between the registered manager and groups of staff. However, it was not clear how frequently such meetings took place and staff told us meetings were usually called only if the registered manager wanted to advise staff of important information.

Minutes from the most recent meeting showed the registered manager had plans to introduce an appraisal system for staff. This should help ensure staff had the opportunity to discuss their personal development with a senior member of staff.

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<br>Treatment of disease, disorder or injury | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br>**The registered person had not taken the appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to meet the needs of people who used the service.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>**People were not protected against the risks associated with the unsafe management of medicines.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br>**The registered person did not have suitable arrangement in place to obtain and act in accordance with the consent of people who used the service in relation to the care and treatment provided for them.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>**The registered person had not taken proper steps to ensure care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services<br><br>**The registered person did not ensure that people were treated with dignity and respect and were involved in making decisions relating to their care and treatment.** |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers<br><br>The provider did not have an effective system to regularly assess and monitor the quality of service that people received. |

**The enforcement action we took:**
A Warning Notice was issued.