MD Care Homes Limited

Aisling 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Aisling Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Aisling Lodge provides care for up to 22 people in one adapted building. Aisling Lodge is not registered to provide nursing care.

The service is in a converted vicarage and accommodation is offered on two floors. There are three lounge / dining rooms on the ground floor. There is a passenger lift for access to rooms on both floors at the rear of the property and a stair lift for access to rooms at the front. Outside, a large walled garden provides secluded and sheltered areas for people to sit and walk in.

This inspection took place on 23 and 31 May 2018. The 23 May was unannounced, but we told the provider we would be inspecting on 31 May 2018. On the first day of our inspection there were 16 people receiving care. On the second day of our inspection, 15 people were receiving care. This was the first inspection of the service since it was taken over by a new provider, MD Care Homes Limited, and registered with the CQC on 16 January 2018.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. And one breach of the Care Quality Commission (Registration) Regulations 2009 (part 4). You can see what action we told the provider to take at the back of the full version of the report.

Processes to assess and monitor the quality and safety of the service had not consistently been carried out to inform the provider if the service was operating safely or not. The provider's systems had failed to identify that they had not always followed their own procedures and failed to identify the issues we found during our inspection. This led to people's care, welfare and safety being compromised.

There was a lack of clear leadership of the service which did not promote an open, transparent culture with positive values. Staff were unclear of their roles and responsibilities and staff were unsure of what they were accountable for and who they were accountable to. The provider and registered manager had failed to notify CQC of all the incidents they were legally obliged to notify us about. Support and resources needed were not always available to run the service in a way that promoted a holistic approach to people's care and ensured all people's needs were being met.

Safe and effective recruitment practices were not always followed. There were not always sufficient numbers of staff deployed to meet people's needs effectively and in a timely manner. Not all staff had received sufficient induction, training, or supervision in line with the provider's policy to ensure they had the knowledge and skills to carry out their roles and responsibilities.

Poor monitoring and management of people's eating and drinking put people at risk of dehydration and malnutrition. Potential risks to people's health, well-being or safety had been identified and assessed.

However, the actions were not always followed and had not all been reviewed. Medicine management systems were safe. However, people could not be assured they would receive their prescribed medicines at night because there was no trained staff on duty to give them.

The provider did not ensure the service was run in a manner that consistently promoted a caring and respectful culture. People's privacy, dignity and independence was not consistently respected and promoted. There was inconsistent support for people to follow their interests and take part in social activities. People were consulted about their care plans, but these had not been updated to reflect changes in people's needs. People were not always involved in every day decisions about their care.

People did not have access to information on how to complain about the service. People could not be assured their complaints would be satisfactorily addressed.

The service was clean and hygienic. Staff knew how to recognise and report any risks to people's safety. Staff met people's day-to-day health needs in a timely way and people had access to health care and social care professionals when necessary to maintain their health and well-being.

People's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision-making process. The service supported people at the end of their life and consulted them and their relatives about their end of life wishes. People were encouraged to maintain and develop new relationships.

This is the first time the service has been rated requires improvement.

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 safe.

There were not always sufficient numbers of staff deployed to meet people's needs effectively and in a timely manner. Not all staff had received training in safety systems.

Safe and effective recruitment practices were not always followed.

Potential risks to people's health, well-being or safety had been identified and assessed. However, the actions were not always followed and had not all been reviewed.

Medicine management systems were safe. However, people could not be assured they would receive their prescribed medicines at night because there was no trained staff on duty to give them.

The service was clean and hygienic.

Staff knew how to recognise and report any risks to people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received sufficient training, induction or supervision in line with the provider's policy to ensure they had the knowledge and skills to carry out their roles and responsibilities.

Poor monitoring and management of people's eating and drinking put people at risk of dehydration and malnutrition.

People's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision-making process.

Staff met people's day-to-day health needs in a timely way and

people had access to health care and social care professionals when necessary to maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not ensure the service was run in a manner that consistently promoted a caring and respectful culture.

People's privacy, dignity and independence was not consistently respected and promoted.

People were not always involved in every day decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have access to information on how to complain about the service. People could not be assured their complaints would be satisfactorily addressed.

There was inconsistent support for people to follow their interests and take part in social activities.

People were consulted about their care plans, but these had not been updated to reflect changes in people's needs.

People were encouraged to maintain and develop new relationships.

The service supported people at the end of their life and consulted them and their relatives about their end of life wishes.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and registered manager had failed to notify CQC of all the incidents they were legally obliged to notify us about.

There was a lack of clear leadership of the service which did not promote an open, transparent culture with positive values. Staff were unclear of their roles and responsibilities and staff were unsure of what they were accountable for and who they were accountable to.

Processes to assess and monitor the quality and safety of the service had not consistently been carried out to inform the provider if the service was operating safely or not. The provider had failed to independently identify shortfalls and had not always followed their own policies.

Support and resources needed were not always available to run the service in a way that promoted a holistic approach to people's care and ensured all people's physical, mental and emotional needs were being met.

Records were not maintained to a satisfactory standard.

Aisling 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place over two days. We visited unannounced on 23 May 2018 and announced on 31 May 2018. On both days the inspection was carried out by one inspector and an inspection manager.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events that the provider is required by law to send us. We also asked for feedback from the commissioners of people's care and Healthwatch Cambridge.

During the inspection we spoke with six people who used the service and one other person's relative. We also spoke with the registered manager, the team leader, a shift leader, four care assistants, a domestic, the chef and a kitchen assistant who also cooks when the chef is not working. In addition, we spoke with the two directors of the provider company, one of whom is the nominated individual. We have referred to the nominated individual as the 'provider's representative' throughout this report. On both days of the inspection we observed the care that people received. We looked at records relating to seven people's care and support. We also reviewed records relating to the management of the service. These included two staff recruitment records, and records relating to staff training, accidents and incidents, complaints, and audits.

After the inspection visits, the registered manager sent us additional information about training on 1 June 2018. We also received electronic copies of the statement of purpose and recruitment and complaints procedures on 19 June 2018.

Requires Improvement

Is the service safe?

Our findings

There were not always sufficient numbers of staff deployed to meet people's needs effectively and in a timely manner. Staff told us that there were enough staff during the two days of our inspection. However, they said that this was not always the case. One staff member said, "We have enough staff today. There are times when we don't have enough." On both days of our inspection there were four care staff, including a senior, on duty during the mornings. However, staff rotas showed that on nine of the previous 24 days, this had been reduced to three care staff, including the senior staff member.

Insufficient staff in the mornings resulted in some people going for long periods without receiving fluids. For example, records showed that one person was in bed for 15 ½ hours and another person was in bed for over 12 hours on one occasion and 15 ½ hrs on another. The registered manager confirmed that these people had not been offered fluids for these time periods. A staff member told us, "We are struggling. We can't give the proper care to [people]. It's not being fair on them. Most of the time we are not getting breaks because we have to make sure people are up." A senior staff member told us the mornings were particularly busy and went on to say that "Lunch is often late because [we are still] providing personal care..."

During the first day of our inspection the lunchtime service was chaotic and disorganised. Staff told us this was primarily because a staff member took their break during this very busy period as they had not been able to take it earlier. This resulted in three of the five people who took their meal in the lounge not receiving the assistance and encouragement they needed to eat their meal. Staff assisted a fourth person to eat two forkfuls of food, but provided no further assistance and the person did not eat any more of their meal. This lack of staff assistance meant that these people ate very little of what they were served and placed them at risk of not having sufficient to eat and drink.

Staff had not received effective induction into their roles resulting in new staff needing a high level of supervision in order to meet people's care needs effectively. For example, a staff member told us they hadn't received training in how to meet the needs of people who were prescribed thickener for their drinks and they could only carry out this task when supervised by other, trained, staff members. Staff said there was insufficient time to read people's care plans and therefore they were not familiar with them. One staff member told us, "We don't read the care plans. We don't have time." A senior staff member said, "Staff do know people but they are so busy they are missing things we've asked them to do." This meant there was a risk of people not receiving consistent, planned, safe care that met their needs.

Not all staff had received training in safety systems and we could not, therefore be confident of their competence in these areas. For example, 17 of the 22 staff who may be required to serve food or drinks had not received training in food hygiene and 15 of the 23 staff had not received training in infection control or health and safety. None of the three ancillary staff had received training in fire safety and the registered manager said she would address this as a priority. This put people at risk of receiving unsafe care.

Staff told us there was insufficient staff to effectively cover when staff were on leave or to receive training. One staff member told us, "I was working too many hours to start with. I would work in the morning and

come back at night." A staff member told us they hadn't received planned training because there had been no staff to cover their shift so they could attend. Senior staff expressed concern that so few staff were trained to administer medicines and this meant they would be working additional days to cover when colleagues were absent.

Although potential risks to people's health, well-being or safety had been identified and assessed, the actions were not always followed and had not all been reviewed. For example, in January 2018, the staff had received guidance from a speech and language therapist to help reduce the risk of a person choking. Although staff were aware of, and were following, this guidance, this information had not been incorporated into their care plan and meant that the information may be missed by new staff.

Staff told us that two people needed to be repositioned every three hours to maintain their skin integrity. However, on the first day of our inspection one person's records showed they had not been repositioned for over six and a half hours. The other persons records showed three occasions in the preceding two days when they had not been repositioned at the recommended frequency. This meant both people may have been at increased risk of their skin condition deteriorating.

This was a breach of Regulation 12 (1) and (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe and effective recruitment practices were not always followed. This meant there was a risk that staff may not be suitable to support people at the service. Neither of the two staff recruitment files we looked at contained all the required information.

One staff member's file contained a check from the disclosure and barring service. However, this was not sufficient for a caring role working with adults because information from the adults barred list had not been requested. The provider had not checked out discrepancies in documentation provided by both new staff to verify their identities and addresses.

Following our inspection, the provider's representative sent us a copy of the provider's recruitment policy. This failed to include all the information required by schedule 3 of the regulation. For example, it made no mention of obtaining proof of identity, including a recent photograph or a full employment history.

Neither of the interview records had been fully completed and neither contained a decision to employ the staff member. This did not follow the provider's policy which stated, 'The assessments made by interviewers must be formally recorded on an interview assessment form.'

Both the staff members records' we looked at contained full employment histories, references from previous employers and declarations that they were fit to work. Staff told us they had been interviewed by the provider's representative and had to wait for them to receive checks, such as references and criminal records checks before they started work. One staff member told us, "I had a brilliant interview with [the provider's representative]. She made me very, very welcome."

Medicine management systems were safe. However, people could not be assured they would receive their prescribed medicines at night because there was no trained staff on duty to give them.

Staff told us the on-call manager would come in to administer medicines to people who needed them during the night. However, this meant there was a 20 minute delay in people receiving the medicines that they needed. A person, who was at high risk of developing pressure sores, had to wait for trained staff to

come on duty to apply a prescribed cream to their body. On the second day of our inspection, staff reported that the person's skin was "pink" when they got up that morning. Staff told us that this was an indicator that a prescribed cream should have been applied. This person told us they were "sore" and "couldn't get comfortable". This meant the person was not receiving their medicine in line with the prescriber's instruction and increased the risk of developing pressure sores.

Medicines were stored safely and administered by trained and competent staff. Medicines records were accurate. Where a person administered their own medicines, staff had assessed the risk associated with this to ensure it was safe for them to do so. We saw there was guidance in place for medicines prescribed to be administered 'when required'. A pharmacist carried out an annual medicines audit and senior staff had carried out monthly medicines audits. These helped to identify any errors at an early stage.

People told us they liked the staff and they responded quickly when they summoned them. One person told us, "Staff come quickly. Unless they are caught up in an emergency, that's just the odd occasion."

The provider's representative told us that their main challenge was retaining and recruiting staff. They said that quite a few staff had left, some with little or no notice. They told us they were actively recruiting more staff. Records showed that six of the 18 care staff, and all the ancillary staff, had been appointed since the provider registered in January 2018.

The provider's representative said that they had introduced a tool to assess the level of assistance people required from staff and this helped determine the numbers of staff on duty.

All care staff had received fire safety training and training in how to assist people to move. Although not all staff had received training in how to control the spread of infections, there were systems in place that helped with this. Staff explained to us the procedures they followed to protect people from the risk of infection. These included regular cleaning, and changing protective equipment including gloves and aprons, and washing their hands between tasks. One person assured us, "Staff do wear gloves and aprons when they help me." A relative told us the service was "always clean and tidy." Overall, we found the service was clean and smelled fresh. However, we noted that the registered manager continued to address a malodour in one person's bedroom.

Staff supported people to use appropriate equipment to reduce the risk of pressure ulcers, for example, air-flow mattresses and pressure relieving cushions. Staff also supported people to use a variety of equipment to help them move around the service. This included hoists and walking frames.

A relative told us that the registered manager had recently identified their family member's deteriorating mobility resulting in the increased risk of their family member falling. As a result, the person was being supported to move to a different bedroom that they could access more easily.

Staff were aware of the provider's reporting procedures in relation to accidents and incidents and the registered manager maintained a log of these. The registered manager reviewed these and recorded their investigation and actions to be taken to reduce recurrence. We noted that remedial actions had been taken to reduce the risk of a further incident. For example, staff noted that one person's call bell had been pulled out of the socket slightly and that when the person tried to summon assistance the alarm was ineffective. Senior staff had communicated to other staff to check these alarms were pushed all the way in before leaving people alone.

The fire safety officer had found deficiencies during an inspection in March 2018. The registered manager

and provider's representative advised us that the improvements would be completed within the timeframe set by the fire safety officer. We saw that some of these had already been implemented such as such as equipment no longer being stored under protected staircases. Staff knew how to respond in the event of a fire and people had personal evacuation plans that reflected their needs on file. This helped to ensure that appropriate support would be given in the event of an emergency, such as a fire at the service. The provider ensured that other checks, such as electrical or health and safety assessments, were also completed to help ensure people's safety. Hazardous chemicals, such as cleaning equipment was stored safely.

People told us that they felt safe at the service. One person responded, "Yes, I do [feel safe]." A relative told us, "I've never once left here with any concerns." Records showed that two of the 23 staff had not received any training in safeguarding people from harm. However, all staff had a good understanding of how to keep people safe and were confident that the registered manager would respond to any concerns they raised. One staff member told us, "If there was anything I was slightly uncomfortable about I'd alert [the registered] manager. I'm absolutely confident if I reported something they'd act on it. I can also contact social services or CQC."

Requires Improvement

Is the service effective?

Our findings

Not all staff had received sufficient training, induction or supervision in line with the provider's policy to ensure they had the knowledge and skills to carry out their roles and responsibilities. For example, 15 of the 23 staff working at the home, had not received any training in health and safety or infection control. Records showed that two of the ancillary staff had not received any training from this provider, both had been in post in excess of two weeks. One staff member described their training and induction. They told us, "I watched colleagues and they explained what they did. I did [moving and handling training and safeguarding training], then I started working." They told us they were working towards a level 2 qualification in dementia care. They said, "I feel I have had enough training [to meet people's needs] now, but I didn't have enough when I started to work [here]." An experienced staff member told us, "Staff are not being inducted and supervised. There's not enough shadowing [of experienced staff]." They told us this meant staff needed constant supervision and there was a risk people's care needs would not be met effectively.

The registered manager told us that the new provider had reduced the time for staff induction and she only had time to provide very basic training prior to the person providing care. She told us, "New staff should have one week working supernumerary, but they get only one day because I can't take people off the floor." She said she prioritised safeguarding and moving and handling training and records reflected this.

The registered manager told us that staff had not been supervised every two months in line with the provider's policy because there were insufficient staff to provide care to enable them to attend these meetings. Two staff who had been in post in excess of two months told us they had not received any formal supervision.

Without formal training and checks of staff competency there is a potential risk that unsafe practices may both be identified. This puts both the people receiving the service and staff at risk of potential harm.

This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that all staff who assisted people to move had been trained to do this. One person told us they were confident that all staff had been trained to use the equipment to assist them to move. They told us, "Yes, they know how to use it. Every so often they say, 'I'm going to borrow your hoist [for training]'. They bring it back after showing others [how to use it]."

People told us that staff knew them and their needs. One person told us staff were "alright. They know what they are doing."

Poor monitoring and management of people's eating and drinking put people at risk of dehydration and malnutrition. Where people had been identified as at risk of not eating or drinking enough, there was no guidance for staff as to people's target food and fluid intake. We could not be confident that people's food and drink intake was being accurately monitored because staff had not consistently completed records

showing if people had been offered, and had consumed, food and drink. A senior staff member told us a person had been referred to a dietician and that it was important that their records were maintained. However, they told us there were lots of gaps on the person's food and fluid chart and that they could not be sure what the person was consuming. There was no evidence that staff had monitored people's food or fluid intake and this put people at risk of dehydration and malnutrition.

One person's care plan had not been updated to reflect guidance received from a healthcare professional regarding their diet. This meant the person was at risk of not receiving appropriate and consistent support to eat and drink.

People had mixed views about the quality of the food provided. Some people required their food to be pureed to reduce the risk of them choking. We saw that on the first day of the inspection the whole meal had been mixed together, resulting in a pale-yellow puree. When we asked the person about their meal, they responded by shaking their head, turning up their nose and saying it was "cold". This person ate none of their main course and staff did not offered an alternative. Another person didn't eat any lunch and staff gave them biscuits as an alternative. This meant we could not be confident that people received sufficient food, increasing their risk of malnutrition.

Insufficient staff during some morning shifts resulted some people going for long periods without receiving fluids. Poor staff deployment during the lunchtime period on the first day of inspection resulted in people not receiving the assistance they needed to eat their meal. This increased the risk of dehydration and malnutrition.

On the second day of our inspection we found the meal time was better organised with sufficient staff being deployed so that people received the encouragement and assistance they required to eat their meals at a pace that suited them. The atmosphere was relaxed and people were offered the choice of eating in the dining room or in the communal lounge. Foods were pureed separately so that they meal looked more appetising and people could taste each flavour. This meant that on this occasion people were supported appropriately to eat and drink in sufficient quantities. However, we could not be confident that this improvement would be sustained.

Records showed staff were monitoring people's weights and we noted most people's weights were stable. Appropriate referrals had been made to the speech and language therapist and the dietician and staff were aware of their guidance. Staff told us, and we saw during our inspection, that they supervised a person who was at risk of aspiration while they were eating, reducing the risk of them coming to harm.

People told us that staff knew them and understood their care needs. One person told us, "Some of [the staff] have been here a long time. They're brilliant. Even the new staff know me. It's not bad at all." People's care needs were assessed prior to them moving to the service. This helped to ensure staff could meet people's needs. These assessments included people's life history, preferences, support needs and their hobbies and interests. The assessment formed the basis of people's care plans which provided guidance for staff on how to meet people's needs consistently. For example, there were clear instructions as to how to support people to maintain a healthy diet and sufficient fluid intake. However, some staff told us they were not familiar with people's care plans and had learned what support people needed from other staff. In addition, the registered manager and team leader told us people's care plans had not been updated even where their needs had changed. Some care plans were missing important information, such as where people needed support with oral hygiene and facial hair. This meant there was a risk people would not be consistently provided with care appropriate to their needs. People's daily care records did not always provide a full account of the care people received. For example, person's care notes did not always reflect

whether they had received assistance with personal care, or repositioning. This meant we could not be certain the care people were offered or received met their needs.

Staff attended regular 'handover' meetings at each shift. This ensured that staff had the most up to date information and helped provide continuity between shifts.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the registered manager had a good understanding of the principles of the MCA. Staff had received training in, and were aware of, the MCA and DoLS. However, their knowledge was limited and staff were unclear as to whether any people living at the service had DoLS authorisations or were free to leave the service unescorted. We asked one staff member to tell us about the MCA and DoLS. They told us, "People have choices about things." Another staff member told us the, "decisions people can make depends on each person. Some people struggle [with some decisions], perhaps they have a high level of dementia, but they can decide what to wear, what to eat, when to get up." They told us they enabled people to make decisions by, "having a chat with them, explain, ask, prompt, and encourage."

We saw the registered manager had obtained copies of any legal representative's authorisation, such as power of attorney. However, we saw that where people had 'do not attempt resuscitation' (DNAR) authorisations in place, these had not always been updated to reflect changes, for example, a change of address. This meant that the DNAR authorisation was invalid.

The service was in a listed building, so minor adaptations had been made to enable people to be able to access the different floors via a lift. However, some bedrooms were only accessed via a short flight of stairs. We saw that with staff support, people were able to access their bedrooms and all areas of communal space. The communal areas had recently been redecorated and bedrooms were going through a programme of refurbishment. In addition, people were able to access the walled garden which had been recently landscaped.

Staff used assistive technology and equipment where appropriate to increase people's independence. For example, staff told us that a person had a pressure mat placed beside their bed that alerted staff when the person was getting up and needed assistance. People who required it were provided with adapted cutlery. A person told us that this made it easier for them to grip the cutlery and eat independently.

Staff did not work together across shifts to ensure people's care needs were met effectively and in a timely way. For example, staff could not tell us the times people had last received fluids or gone to bed the previous evening. Therefore, staff did not use this information to help inform their rationale of when they assisted people to get up and as a result we saw that some people were spending in excess of 12 hours in bed without fluids.

Staff met people's day-to-day health needs in a timely way and people had access to health care and social care professionals when necessary to maintain their health and well-being. People told us and records showed they were supported to access a range of healthcare professionals such as GP, dieticians, opticians

and chiropodists. One relative told us when they had noticed their family member was unwell staff had already arranged for the GP to visit. They indicated that staff only call in health care professionals when necessary. They said, "The timing is good – not too quick, but it's just right." We found that the staff team promptly identified changes to people's health.

Requires Improvement

Is the service caring?

Our findings

The provider did not ensure the service was run in a manner that consistently promoted a caring and respectful culture. For example, staff were not always provided with sufficient time for training and to understand people's needs and wishes. People and staff told us how busy staff were and that this meant people could not choose when or how their care was provided. We asked a person if staff had the time to help them, they said, "It's difficult to answer that. It depends on what's happening." They went on to tell us, "I can't really choose when I get up because so many [people] need help. I do have to wait." Staff repeatedly told how busy they were, especially in the mornings. A staff member told us, "We are rushing. The morning shift is really under pressure... We are trying our best. We don't have time for conversation. It's always very busy here. There's no time for friendly chat." Another staff member told us that the staffing levels often meant people's "personal care needs to be done quickly." They explained there wasn't enough time to give them the time they needed.

People's care was not consistently personalised to meet their individual needs. For example, one person told us they couldn't choose the time they got up because they had to wait for staff to help them. Two people expressed to us they didn't like having facial hair. They told us they used to be clean shaven and photographs supported this. We could see from one person's records that they needed considerable support with personal care and that there were guidelines for staff on how to encourage the person with this. The person's daily notes showed that few days before our inspection a staff member had supported the person to have a partial shave, but that the person had refused this support part way through. Records did not show whether staff had offered the person further support. There were no recent records to show the other person had been supported with this element of their care. Neither person's care plan contained any information regarding the decision to grow their facial hair.

People's privacy, dignity and independence was not consistently respected and promoted. For example, a staff member told us we could enter a person's room. However, the person had no trousers on and was sitting with a rug over their feet. We asked if they would like us to cover their legs and they nodded. The rug stayed on the person throughout our conversation. We saw staff assisting people to eat by standing in front of them, rather than sitting beside them. We were in a person's room with them and a staff member when another staff member entered and spoke with the first staff member, ignoring the person.

We did see examples where people were treated with respect. For example, staff addressed people using their preferred names and knocked on bedroom doors before they went in. People looked well cared for: their clothes and glasses were clean and their hair was combed. A relative told us, "[My family member's clothes are always clean and [their] personal hygiene is always acceptable." They told us how staff had been "diplomatic" when raising issues that could cause offence. The relative said the service had "a heart that ticks" and that staff supported their family member to "be [their] own person".

People and their relatives were complimentary about the staff. One person described staff saying, "Staff are alright. They're quite good. If you want anything they'll get it for you." Another person told us, "The majority [of staff] are very good." A third person said, "The staff are very good. [They're] all kind and thoughtful." A

relative described staff as being, "Courteous, polite, nothing too much trouble [for them]." Staff provided people with comfort and reassurance. One person commented that staff reassured them and "say not to worry" when the person felt embarrassed by the assistance they required.

A relative talked about how staff involved them and their family member in decisions. For example, when the person first moved to the service they were encouraged to bring in items of furniture to help them feel at home. The person was being supported to move to a bedroom that better met their needs. Again, they told us that they and their relative were being consulted about this and asked for their views on the redecoration of the room. An ancillary staff member told us how they have got to know people and when they like their rooms cleaned, citing two people who preferred the cleaning to take place during meal times, when they were not there. The staff member said, "We can adjust as necessary" and talked about varying their routine when a person had visitors.

Staff told us that relatives and friends of people who used the service were encouraged to visit. A relative told us that staff welcomed them when they visited. They told us how they were often offered a drink, they said that staff don't "have to look after me as a visitor" but that they did. They referred to a staff member on duty saying they brought "a warm feeling to you every time you come in."

Requires Improvement

Is the service responsive?

Our findings

There was no information displayed in the service that advised people how to complain if they were unhappy with their care. The registered manager told us this had been taken down during the recent redecoration and had not been replaced.

The registered manager and the provider's representative told us that they had received one complaint since registration. This contained several elements. The provider's complaints procedure stated, 'How we handle complaints, when we have finished investigating, we will arrange to meet with you … and write to you with details of the findings, any actions we have taken and our proposals to resolve your complaint.' The provider's representative had met with the complainant within the timescale stated in the provider's complaints procedure and we saw their brief notes of this meeting. However, there was no clear record of an investigation into the points raised. After the meeting the provider's representative wrote to the complainant advising them of the actions they had taken in response to one element of their complaint, but there was no record regarding their findings or actions in relation to the other elements. This meant the provider's complaints procedure had not been followed and people could not be assured their complaints would be satisfactorily addressed.

Following our inspection, the provider's representative sent us an updated complaints policy, with the current provider's name and contact details. The policy had been amended but lacked clarity regarding the records that would be maintained. For example, it stated, 'When we have finished investigating, we will arrange to meet with you to discuss the outcome', with no reference to the provider writing to the complainant regarding the outcome of their complaint or maintaining a record of the investigation, outcome or actions taken.

This was a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that they knew how to raise concerns and were confident that the registered manager would address any issues promptly. A relative told us, "We can always talk with [the registered manager] or telephone her. She will always take your call or get back to you within [agreed timescales]."

There was inconsistent support for people to follow their interests and take part in social activities. On the first day of our inspection a musical entertainer visited during the afternoon, on the second day of our inspection we saw a staff member playing dominoes with a person in the lounge. These were the only two occasions we saw people supported to be occupied over the two days. The provider's representative told us they provided external entertainment and that staff did not get involved in the providing "activities". This separation meant that we saw numerous missed opportunities for engagement and involving people in meaningful interventions, such as familiar daily tasks. This resulted in people experiencing a lack of mental and physical stimulation. People spent long periods of time in the communal areas or their bedrooms, sometimes with the radio or television on, neither of which engaged the majority of people, leaving them looking around or dozing. This was particularly the case for people who required higher levels of staff

support and were living with dementia. Staff told us they didn't have the time to spend chatting to people or engaging them in meaningful activities of daily living. One staff member told us, "[There] needs to be more activities for [people]. We used to play games and have conversations, but at the moment we haven't time." Another staff member said, "There's no activities…There's not enough staff." One person who had recently moved to the service told us, "I can get about…I sat in the garden a couple of weeks ago. I would like to go to the shops. I haven't seen any shops for about two years…. We don't do a lot here at the moment."

We saw that people's hobbies and interests were recorded in their care plans and where people were more able, they pursued these, mainly in their bedrooms. For example, one person's care plan said they were a musician and liked listening to music. We saw they had recordings of music, and the ability to play them, in their room. Another person told us their radio was tuned so they could listen to their preferred station and we saw pictures of them planting up flower pots in the garden. They told us, ". I sit in the garden sometimes. That's nice. It's nice to get fresh air." Another person told us, "I don't want to go out. I've got my TV, I can nap. I suppose it's alright. I stay in my room. I've got my own things around me. I watch the birds [out of the window]."

People were encouraged to maintain and develop new relationships. A relative told us they felt welcomed in the service. They said their family member had developed a friendship with another person at the service. They told us their family member, "Often sits next to a [person my family member] feels comfortable with and they have [things to discuss]." They said that staff had noted and encouraged this relationship by supporting the people to sit next to each other in communal areas.

A relative told us that they and their family member had been consulted about the person's needs and their care plan. People's care plans contained detailed information about them and how staff could support them to meet their needs. However, the registered manager told us that some people's care plans had not been updated to reflect their current needs and we saw this was the case. For example, one person's care plan did not reflect guidance provided by the speech and language therapist in January 2018. Another person's care plan reflected lots of information regarding the person's preferences around mealtimes. However, this had not been updated to reflect the current level of assistance the person required.

The service supported people at the end of their life and consulted them and their relatives about their end of life wishes. The registered manager and four of the 19 staff providing care had received training in end of life care. Records showed that some people's wishes had been discussed with them and or their relatives. A relative told us, "We [the registered manager and relative] had discussion initially, and then after about three months to review about what [my family member] and I want." They told us this gave them an opportunity to discuss this with their family member. People's wishes were recorded in their care plans, including who to contact if the person required additional pain relief. However, we noted that one person's end of life care plan was blank. There was no information to indicate whether this had been discussed with the person, or if relevant, their relatives. This meant there were no clear directions for staff as to the person's wishes should the person require this type of care.

Inadequate

Is the service well-led?

Our findings

We found the provider and the registered manager had failed to notify CQC of all the incidents they were legally obliged to notify us about.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

A new provider had taken over the service in January 2018. The provider's representative visited the service three or four times each week and told us she was "very involved" in the running of the service.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. People and relatives made positive comments about the registered manager. The registered manager had also been registered with the CQC to manage the service under the previous provider.

There was a lack of clear leadership of the service which did not promote an open, transparent culture with positive values. One staff member described the relationship between the registered manager and the provider's representative as, "Tense." Another staff member told us, "There's no proper communication so we don't all know what's going on." There had been two staff meetings since the provider took over the service. These were chaired by the provider's representative and neither the registered manager or the team leader were present. The provider's representative confirmed that no minutes of the meeting had been produced and staff not present at the meeting had not briefed of the content. The registered manager expressed how difficult it had been to manage the service when she was not aware of decisions that were being communicated to staff. This meant that decisions had not been effectively communicated to the whole team and the provider and staff did not have a shared vision and values.

Staff were unclear of their roles and responsibilities and staff were unsure of what they were accountable for and who they were accountable to. One staff member told us they did not have a job description and another said they had been asked to attend additional training and responsibility and were not sure if their job role had changed. A staff member said, "It's been a nightmare. There's no communication… It makes it miserable to come to work. We don't know who's in charge." Some staff told us they would not always report concerns to the registered manager or the provider because they didn't know who was in charge and were not confident their concerns would be addressed. One staff member said of the management team, "I don't know who to trust." This put people at risk of concerns about people's care not being raised and investigated.

The lack of clear leadership had resulted in poor staff morale and what one staff member described as "Quite a turnover of staff." Records showed that nine of the 23 staff who worked at the service had been employed since the new provider had registered in January 2018. Staff told us that other staff left within a few weeks from starting employment because they could not tolerate the differing messages they received

from the provider and the registered manager. Talking about the changes in staff, one person told us, "[There's been] so much upheaval." A staff member told us, "No one seems happy."

Processes to assess and monitor the quality and safety of the service had not consistently been carried out to inform the provider if the service was operating safely or not. The provider had failed to independently identify shortfalls and had not always followed their own policies. These are identified throughout this report and include failures relating to recruitment processes, medication practices, staffing levels and deployment, training and support, complaints investigations and the poor standard of record keeping. This lack of governance put people's health, safety and wellbeing at risk and meant care was not always provided in a way that promoted people's dignity and respected people's personal preferences.

The provider's representative told us the service was "very resident led", however, we did not see evidence to support this view. No meetings involving people living at the service and or their relatives had been held since the new provider registered with us. The provider's representative said, "I speak with residents and get feedback from them. I do spot checks in rooms and make sure that water jugs are filled." However, there was no evidence that any information had been collated and analysed or her findings fed back to people or staff. The provider's representative was unable to demonstrate how the views and experiences of people were explored and promoted and showed a lack of effective oversight of the service.

Support and resources needed were not always available to run the service in a way that promoted a holistic approach to people's care and ensured all people's physical, mental and emotional needs were being met. Staff were not always effectively deployed and the care provision was task led rather than centred on people's individual needs and wishes. The service was experiencing problems in recruiting and retaining care staff, and covering staff absence. This posed a significant challenge to ensure that new staff were trained and competent to providing care and put considerable strain on the other staff members. The lack of leadership and inadequate staff supervision meant that risks to people's health and welfare were not closely monitored.

This was a breach of Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives were aware of this change of ownership and had met or received letters from the provider's representative. One person told us they saw her, "Occasionally" and said, "She seems very nice." They also knew the registered manager and team leader and described good, established relationships with them.

People and relatives made positive comments about the registered manager. The registered manager had also been registered with the CQC to manage the service under the previous provider. One relative described her as the "main stay" in the service and that they "could not have wished for better."

The provider's representative told us they attended meetings run by the local authority which had provided them with support and an awareness of current guidance and best practice.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and registered manager had not notified CQC of all the incidents they were legally obliged to notify us about. Regulation 18 (1) (2) (a) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk because they were not always provided with safe care and treatment. Regulation 12 (1) and (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not robust and operated effectively to ensure risks to people were mitigated and to ensure a good quality of service was provided. Regulation 17 (1) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff deployed who had received suitable induction, training, and supervision to ensure they had the knowledge and skills to carry out their roles and responsibilities. Regulation 18 (1) (2)(a)