White Ash Brook (Accrington) Limited

White Ash Brook

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection of White Ash Brook on the 26, 27 and 31 August 2015 and 14,15,16 September 2015. This was the first inspection of the service since the registration of White Ash Brook (Accrington) Limited in April this year.

White Ash Brook Nursing Home is a purpose built home registered to provide nursing and personal care for up to 53 people. Accommodation is provided in single en-suite rooms located on the ground floor. Communal lounges and dining rooms are also on the ground floor. The gardens are easily accessible to people using the service. The home is situated in the small town of Oswaldtwistle and close to local amenities. There is a car park for visitors and staff.

There was a registered manager in day to day charge of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Before this inspection we had received concerns regarding inadequate staffing levels and details of how this was impacting on the care people were receiving. During this inspection we found staffing levels were not sufficient to ensure people's care and welfare. People told us they felt safe in the home and they were treated well by staff. However people also told us they did not get the attention they needed when they needed it. This had impacted on their well-being and we saw occasions during our visit where people's dignity had been compromised as a result. You can see what action we told the provider to take at the back of the full version of the report.

Before this inspection we had received concerning information in relation to medication errors. During this inspection we found there were shortfalls in the ordering, administration and disposal of people's medicines that could result in mishandling or error. One person we spoke with told us they had concerns as to the time they got their medicines. You can see what action we told the registered provider to take at the back of the full version of the report.

During this inspection we found infection control was not being managed appropriately. This meant people were at increased risk of contracting an infection. You can see what action we told the registered provider to take at the back of the full version of the report.

Before this visit we had received concerning information about incidents of assaults that had occurred in the home between people who were living with dementia. Whilst these had been dealt with at the time of our visit, we found managing risk overall was not sufficient to ensure people were cared for safely. You can see what action we told the registered provider to take at the back of the full version of the report.

Staff we spoke with were aware of their responsibilities to safeguard people from abuse and were confident to report any such concerns. Principles of the Mental Capacity Act 2055 (MCA) had not been fully embedded into practice and we found some concerns over how best interest decisions were handled. We have made a recommendation regarding this.

Before this inspection we had received concerning information people did not get a drink mid-morning and in the afternoon. People we spoke with told us staff did not always give them a drink, although one person said they could have a cup of tea at any time. Meals served were nutritious and portions served were generous. However not everyone who needed assistance to eat and drink was given this support. Supervision people needed during meal times was poor. We had concerns how nutritional monitoring was carried out. You can see what action we told the registered provider to take at the back of the full version of the report.

Staff providing care and support for people were not adequately supported to undertake their role effectively. We found they were not regularly supervised, appraised or trained in more specialist care to support them and make sure they were confident, safe and competent to provide people living with these conditions with effective care. You can see what action we told the registered provider to take at the back of the full version of the report.

We found people's charts had gaps in recording which made it difficult to determine whether they were receiving their care safely and appropriately. We also found care plans and risk assessments were not properly completed. We were told new documentation was being introduced which would improve this. You can see what action we told the provider to take at the back of the full version of the report.

All but one care plan we looked at provided staff with sufficient information to care for people properly and staff told us they did not routinely read these. Communication regarding people's care was not effective to ensure staff were kept up to date with people's needs. You can see what action we told the registered provider to take at the back of the full version of the report.

The number of shortfalls we found indicated quality assurance and auditing processes had been ineffective. There was evidence of limited monitoring and support from the registered provider to ensure the registered manager was achieving the required standards in the day

Summary of findings

to day running of the home. Checks on systems and practices had been completed by the registered manager but matters needing attention had not always been recognised or addressed. This meant the registered providers had not identified risks to make sure the service ran smoothly. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The service was not safe.

People were happy with the staff but there was insufficient staff to meet their needs and ensure their safety. Staff were not all familiar with managing risk.

People's medicines were not always managed safely.

Infection control was not managed well and we found a number of areas were in need of attention to ensure the environment was clean and safe for people to live in.

Is the service effective?

Inadequate

The service was not effective.

People's nutritional needs were assessed but not effectively monitored. People requiring support to eat and drink did not always get this.

Staff were not supervised or appraised with any consistency. Staff did not always know people's needs and did not routinely refer to care plans or were provided with up to date information regarding people's needs

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate action was taken to make sure people's rights were protected. Best interest issues were not always recognised. People had access to healthcare services and received healthcare support.

Is the service caring?

Requires improvement

The service was not consistently caring.

People praised staff for being kind and caring and we observed staff deliver care with kindness and compassion. People using the service told us they were able to make decisions and choices. People told us staff did not have the time to get to know them.

Staff did not have the time to respond in a timely manner to people's request for assistance resulting in people's dignity being compromised. People's dignity was also compromised with a lack of support with personal hygiene and supervision with personal care.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People told us they could raise any concerns with the staff or managers. Relatives did not all have confidence issues they raised were dealt with appropriately.

Summary of findings

People had care plans based on their assessment of needs but some of these were incomplete and not reviewed in line with people's changing needs. Communication was not good in ensuring all staff were kept up to date with people's presenting needs.

People were supported to take part in a range of suitable activities. People were able to keep in contact with families and friends. The impact of people at risk of social isolation was not considered.

Is the service well-led?

Inadequate 

The service was not well led.

There were systems in place to seek people's views and opinions about the running of the home. People had opportunities to have their say about the quality of the service, but their views were not always considered or changes made as a result of this.

The number of shortfalls that we found indicated quality assurance and auditing processes had not been effective. Matters needing attention had not been recognised or addressed.

White Ash Brook

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26, 27 and 31 August 2015 and 14,15,16 September 2015. The first and fourth day of the inspection was unannounced.

The inspection was carried out by one adult social care inspector, one pharmacist inspector, one specialist nurse advisor (present on the first day of inspection) and an expert by experience also present on the first day of the inspection. 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 service was visited on the third day of inspection to gather evidence that was previously not available. An inspection manager accompanied the adult social care inspector for the fifth and sixth day of the inspection.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We looked at information that had been sent to us from two 'share your experience' forms. We also considered information we had received at a Quality Improvement meeting we had attended which was led by the Local Authority. Further information of concern was received during the course of our inspection.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with nine people living in the home, five visitors, and two visiting health professionals. We also spoke with two agency staff, four nursing staff, and seven health care staff, two domestic staff, the deputy manager, the registered manager and a service manager. We observed care and support being delivered by staff. We looked at a sample of records including five people's care plans and other associated documentation, training and supervision records, minutes from meetings, complaints and compliments records, thirteen people's medication records, policies and procedures and audits. We also looked at sample results from a recent survey that had been completed by relatives. We looked around the premises.

Inadequate

Is the service safe?

Our findings

Some people we spoke with could not give us a verbal account of their experience. We therefore observed their care and support throughout our visit and we spoke with relatives who were visiting. Other people we spoke with could tell us how they viewed the care they received and if they felt safe. One person told us, “I feel safe here because if there is an emergency I feel there is someone around to help me. I'd speak to one of the carers if I had a problem and they would try their best to put it right.” Another person told, “I feel safe because I'm treated well.” And another person told us, “I feel safe here because the area is nice and tidy most of the time and I can get around. If I was worried about something I would tell my relative or the nurse. My family would make sure it was sorted out.” Near the end of our visit one person told us, “I’d be dead now if it wasn’t for this place. I feel they have saved my life and I have no regrets coming here.”

We looked at how the service protected people from abuse and the risk of abuse. Before the inspection we received detailed information from the local authority’s safeguarding team. This information highlighted a number of concerns about the safety of people using the service. The concerns were considered as part of the inspection of the home.

Before this inspection we had received some concerning information regarding the numbers of staff on duty and how this was impacting on people’s care. Issues raised included, a reduction in staffing which meant at times some staff had to work alone. Relatives had complained about the staffing levels at the home and that their relations care was poor. There was also a concern that people were at risk of not receiving personalised care as they required and this impacted on their nutrition, pressure care, and personal hygiene. We were told people using the service needed a lot of support because of their care needs or because they exhibited behaviours that challenged the service. Sometimes staff were assaulted and there was an increased risk of accidents and injuries occurring.

All the people we spoke with and their relatives who were visiting, commented on the level of staff that were on duty daily and the impact this had on the care and support provided. Comments included, “I do have to wait for help during the day. There just isn't enough staff. At night it's extremely problematic because of agency staff who just don't know me or what I like. I sometimes feel a bit isolated, particularly at night time.” “There are two night staff which includes the senior but the senior does the medicines. If there are emergencies there is no staff to answer the buzzer. There is severe dependency here amongst residents, and only one member of staff.” “There isn't enough staff. I've seen residents waiting and waiting. Staff say "Just a minute", but then you have to wait more than half an hour for help.”

A relative we spoke with told us, “There is a chronic shortage of staff which may have caused the last incident with my relative. It is a vicious circle: staff are overworked, under pressure and leave which just exacerbates the problem.” Another relative told us, “There should definitely be more staff. I have seen residents waiting for attention and getting agitated because their needs are not being met.” One visitor when asked how they found the care for their relative explained that the “Main thing - not enough carers – not enough, definitely not !” The relative continued to explain that, the care when it was given was quality care when they got it, but recently their family member had to wait for two and a half hours to go to the toilet. They did feel that the staff were wonderful, but there had been a lot of staff changes and the number of staff at weekends was worse. In a relative survey we noted one person had commented, “There are times when there are no staff (20mins) in the main room. I have had to intervene between residents more than once. I have witnessed assault.”

Staff we spoke with commented on staffing levels. “We are very busy and we are faced with challenges every day. There is just not enough time to spend with people.” Another staff member told us, “Time is an element to providing personalised care and we can be short staffed. We just don’t have enough time to spend with people and give them the care we want to give them. The experience here is poor and staff morale is low.” And another staff said, “The job is stressful and I’m genuinely concerned for people we are caring for as staff can’t give them 100%.” We were told the company had on occasions sent a nurse when on duty to another service within the company to cover their shortage and this was confirmed by a staff member. This meant there was only one nurse left at White Ash Brook to cover a 12 hour shift. A staff member also said, “Personally I do not think there is enough staff and I think every day residents' needs are not being met. I think both carers and residents are suffering because of this.”

Inadequate

Is the service safe?

Staffing rotas demonstrated that there had been some reduction in staffing numbers over time and the registered manager stated that this had happened even though there were more people residing at the home and that the needs of people at the home had increased. The rotas showed that there was a high sickness and absence rate and that there was a high reliance on agency staff usage. Rotas showed that there were many instances of when staff were sick and absent. On one day of the inspection 5 staff rostered for duty either rang in sick or were absent. There was a lack of action by the manager to determine when and if these staff members would be returning for duty.

We observed staff response in attending to people's needs as required. We found calls for assistance were not answered promptly and staff did not appear to have time to support people when they needed this, particularly during meal times. For example we heard one person shouting "Please come and help me please. Staff come and see this, you've got to come. Please help me," over and over for over fifteen minutes for someone to help them. Staff were very busy with other people and did not engage with the person at all. We observed how this failure to respond to a call for assistance had seriously compromised this person's dignity.

The provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced persons to keep people safe. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at seven staff recruitment files. We found a safe and fair recruitment process had been followed and checks had been completed before staff began working for the service. These included the receipt of a full employment history, an identification check, written references from previous employers and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We were told regular checks were undertaken on the registration status of nursing staff.

We asked people if they had their medicines when they needed them. One person told us, "I have one tablet at night. I know what it's for and I'm given it on time." Another person said, "I'm on loads of medications. They (staff) have explained what they are all for. Half the time they don't give them to me until it is much too late. I'm on morphine and need this at regularly spaced times. When they give them to me late, it sends all the rest of the day's medications out of time. They are too busy and distracted by other resident's needs and then medications get given later and later." A relative told us their relation had cream prescribed to prevent redness of the skin, but it was not uncommon for the prescription to run out and their relation had to wait for up to a week to have this replenished. We observed one person was given medication that dissolved in water. Staff serving lunch were asked to make sure they took it. However this was taken away by staff after lunch when they were clearing the tables. We saw cream provided for one person in another person's bedroom.

We checked the medicines and records for 13 people. We spoke with an area manager, a deputy manager, three registered nurses and one senior care worker with responsibility for medicines.

We saw that morning medicines were still being given to people at 11am. We watched a staff member giving medicines to three people and this was done in a friendly and caring way.

Medicines were not always given as prescribed by the doctor. For example, a person who was taking a medicine to thin their blood had been given the incorrect dose on one day. A second person who had been discharged from hospital was not given their medicine despite it being in the medicines trolley. A third person did not have their corticosteroid cream (a cream used to reduce redness and inflammation of the skin) for over a week as it had not been delivered. A fourth person who refused to have their medicine for over a week was not well managed and appropriate action did not take place. We also saw medication that had been discontinued in June had been given for two consecutive months after it was stopped. Communication about changes of medicines or requirements for residents was not always effective. For example a nurse had not been told that a person had recently been discharged from hospital and had arrived by ambulance for a few hours after.

We found that care records were not easy to find as the home had two systems for recording information, one was on the computer and the other was a paper record. Fluid balance charts (a chart to record the amount of fluid a person takes in a day) and weight checks were not always completed. Two people needed to have the amount of fluid taken monitored closely to reduce their risk of dehydration.

Inadequate

Is the service safe?

The same two people had their medicines crushed and mixed with water before being given to them. There was incomplete fluid balance charts for both people and the fluid balance chart did not include the water used to mix the medicines in. There was no risk assessments completed for medicines being crushed and furthermore there was no guidance for the nurses to how this should be given correctly. Three of the nurses we spoke with had not given medicines in this way before, and had not been given any formal training, which is a risk as they might not have the right skills and competency to manage this safely. The same nurses also said that they did not have time to read the home's current medicines policy and could not say where it was located.

Medicines were not always safely locked away as the fridge was unlocked in one room and creams for several people were left on a trolley in a corridor that could be accessed by anybody. Minimum and maximum fridge temperatures were not recorded as per national guidance. The current temperature was recorded, but there was some records missing and some temperatures were outside the recommended range. A urine sample was stored in one of the medicine fridges, which is against infection control guidance. Powder used to thicken fluid for people with swallowing difficulties was not always locked away as we saw this in one bedroom and in the dining room area, which is contrary to current guidance.

Medicines audits had been completed for a small sample of people each month. However staff were unaware of the results so there was a risk that learning from incidents would not be properly shared and acted upon. This was a concern as there had been a recent error where a medicine used for the skin was given to a person by mouth by mistake. During the visit we found care planning such as a risk assessment or a body map to support nurses in managing this type of medicine safely were not in place.

The provider had failed to assess the risks to the health and safety of service users of receiving care or treatment, ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely and had failed in the proper and safe management of medicines. This was a breach of Regulation 12(2) (a), 12(2) (c) and 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent some time in the lounge area. In the morning we noticed one person had very dirty finger nails. Despite bringing this to the attention of staff, the persons' nails were not cleaned by tea time and we had witnessed this person touching faeces that were on a dining table at lunch. This placed the person and others at an increased level of the risk of infection. We also observed wheelchairs being used for people that were very dirty and two cushions for wheelchairs in use were ripped and heavily stained and were a source of bacterial growth. We were told there was a cleaning schedule for wheelchairs, however the food debris was ingrained and the cushions were stained. During our inspection we noted several people had diarrhoea and four staff had rung in sick with this complaint. The registered manager told us she did not think it was an outbreak of infection and contributed the symptoms to 'being on antibiotics' and there had been no further reported cases after 24hrs. We noted a further staff member had reported these symptoms after the 24hr period. This outbreak had not been brought to the attention of the relevant authority.

One person had a rash. We were told the rash was a symptom of an infectious skin complaint. We asked a member of staff what protocol was being followed to minimise the risk of cross infection to other people and staff. We had observed a member of staff had included this persons' protective apron with other people's that were gathered for the laundry. They told us they were not sure and had not seen any written protocol to follow. We asked the senior staff on duty if there was a written protocol to alert staff on what they should do when handling infected laundry. We were told they had not seen one but infection control involves using gloves and aprons and that linen was put into a red laundry bag to be washed separately. One staff member on duty was not aware of the infection until after lunch despite having started work at 8am. We looked in the persons records and found there had been a short term care plan written for this. Failing to follow correct procedures for the prevention of cross infection placed people using the service and staff and visitors at increased risk of infection. We looked at the staff training record. We identified most staff had received training in infection control.

An infection control policy has been recently introduced at the home however this is very brief and concentrates

mainly on reactive intervention following an outbreak. There is little information in the policy to direct staff as to good pro-active measures of infection control based on Department of Health guidance.

We looked at the daily handover record used by staff to brief other staff when they came on duty. We noticed staff had reported a relative had complained their relations room was dirty. We looked around the environment and randomly selected bedrooms to look in and found areas that were unclean. For example we saw one bed that had been made but that had a urine stained sheet which had been left on. We saw a valance on a bed with urine and faeces stains evident.

Two en-suite facilities were used as storage for aids such as commodes, wheelchair and frames which covered the whole floor space. Wound dressings and catheters were also seen amongst the items and near the toilet. We saw a soiled incontinence pad on the floor in an en-suite and several rooms smelt strongly of stale urine. Carpets on the corridors were stained and paintwork was chipped on skirting boards and doors. At lunchtime we saw cornflakes and paper serviettes on the dining room floor. We saw a box of topical medicines (creams) prescribed for people, on the bed changing trolley that was dirty and left beside a red laundry bag used for collecting infected/soiled linen.

We have shared our concerns with the infection control lead at the Local Authority.

The provider did not have adequate infection control measures in place at the home. This was a breach of regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed risk. We saw a wide range of risk assessments in use in care documents including Waterlow (pressure ulcer risk assessment/ prevention policy tool), MUST (Malnutrition Universal Screening Tool), falls, and moving and handling. However these were not always completed for people clearly identified at risk and there was evidence where actions to be taken by staff to minimise and reduce the risk, this was not always followed by staff.

We saw an example where one person's risk assessment clearly stated they were at risk of urinary tract infection (UTI). Staff were instructed to 'ensure plenty of fluids'. We looked at their record of fluid intake for one day of our visit that showed 450ml intake over a day which is too low.

Other records we looked at showed the person on a number of occasions had a poor fluid intake. The person had also fallen in the home that had resulted in an injury. We noted the person has a history of falls, however despite this, there was no risk assessment for falls prevention completed.

Another person had a pressure ulcer that was currently being treated at the home. It was difficult to determine the state of or the grade of a pressure ulcer as this had not been routinely assessed each time it was dressed. This meant staff would not necessarily know if there was any deterioration in the condition of the pressure ulcer or report any changes. Equally we saw the person placed on their back whilst in their bed although their care plan for pressure relief stated the person should only lie on their side.

We found liquid bathing products were left in en-suite facilities. This placed people with limited capacity to recognise these products at risk of accidently swallowing them. We saw that one person who had experienced a choking episode where staff had to support them, did not have a risk assessment completed following this. The training record showed four staff had training in risk assessment. By failing to ensure people had adequate risk assessments and by failing to make sure staff followed risk management plans placed people at a risk of not being cared for appropriately.

Before we visited the home there had been a number of incidents of altercations between people using the service reported to us that had been referred to the local safeguarding team. From our discussions with staff, other people using the service and relatives we were concerned about staff's skill in handling behaviours that challenged. Not all staff we spoke with were familiar with existing risk assessments for people and had not read care plans. One staff member who said she had been at the home for two years said that she had only managed to read "about six care plans". Staff told us they took guidance from more experienced staff. Staff reported being assaulted, and we saw one staffs arms covered in scratches they reported was a result from providing care intervention. We looked at the training record and noted approximately less than thirty percent of staff had completed restraint or managing challenging behaviour training and only four staff had

Inadequate

Is the service safe?

received training in risk assessment. The registered manager told us training was planned for. Without formal guidance, people may be at risk of receiving inappropriate or unsafe care.

The provider had failed to identify and minimise risk and to make sure people providing care or treatment to people have the qualifications, competence, skills and experience to do so. This was a breach of regulation 12 (2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safeguarding vulnerable adults procedures and 'whistle blowing' (reporting poor practice) procedures for staff to refer to. Safeguarding vulnerable adults procedures are designed to provide staff with guidance to help protect vulnerable people from abuse and the risk of abuse. Staff told us they had received appropriate safeguarding vulnerable adults training, had an understanding of abuse and were able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. However, in practise, our observations indicated staff lacked an awareness into the full meaning of abuse as there appeared to be a lack of understanding of abuse by omission of care.

Where there was evidence of shortfalls in the safety of people who used the service this was not effectively acted on or changes in care initiated. We could not be confident that the management of incidents, accidents, pressure ulcers, nutritional monitoring and safeguarding was effective.

Whilst care records demonstrated that some accidents had been reported there was a lack of effective systems to ensure there was managerial oversight of accidents occurring at the home. Whilst the manager was aware of this problem, effective processes had not been put in place to ensure that this took place.

Inadequate

Is the service effective?

Our findings

Before this inspection we had received concerning information that staff were so busy they did not always give people a drink during mid-morning and in the afternoon. We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals. They told us, “I can ask for a cup of tea any time I want. I like all the food. It's not bad at all. I get enough to eat. I've a good appetite and I like my food. I'm not weighed at all.” “The food is very good. The steak is very good. I've only been here a couple of weeks but staff have weighed me.” “The food is good. Sometimes the meat is a bit 'babyfied' and I like my meat in slices. I have a good appetite.” We were also told, “It's a long time to wait in the dining room from sitting at the dining table to the food being served. You don't get enough to drink. Mid-morning and afternoon brews seem to have disappeared.” And “Staff don't always offer me drinks in the morning breaks but I do get a drink in the afternoons. I also get a bedtime drink of hot chocolate but sometimes they have run out of it and I have to have a cup of tea.”

Relatives we spoke with commented, “As far as she is able she does have everyday choices in her life. She can and does choose what she eats. She gets enough to eat and drink and the food appears to be nutritious. Sometimes I have noticed that not all residents have a drink.” And “My relative does get enough to eat and drink.” “He enjoys his food. I stay and make sure he eats it. He has a cooked breakfast nearly every day.” “There is not enough staff around to make sure people eat enough and sometimes they do not get a drink, I think it’s because they are short staffed.” And, “The lunch time system seems chaotic. Some residents need feeding and some residents can feed themselves. It can take up to forty minutes to give everyone the main meal. Some residents who have eaten are then kept waiting for their pudding until everyone has finished the main meal.”

On all the five days of our visit we saw that some people were being served breakfast at 11am. A trolley was used to carry the prepared food that consisted of a bowl of porridge, jam sandwiches and toast. On two occasions we felt the bowl of porridge and found it to be cold. On the last day of our visit, the nurse on duty in the Stanhill wing told us most people were up but there were about four people in bed and staff were attending to their needs. We discussed this with the area manager and registered manager as this meant the times between breakfast and dinner was about one and a half hours with the evening meal being served at 5pm. This meant that some people were having all their meals for the day in a six hour period. They agreed this was not acceptable and should not happen.

We also observed lunch being served. There was a dining area on each unit. The dining tables were appropriately set and condiments and drinks were made available. People were able to dine in their rooms if they preferred. The meals looked appetising and the portions served were ample.

However we saw that people were sat at the tables for over 15 minutes before their meal was served. Not everyone at the table were served together. Some people were very restless waiting for their meal and became agitated. On the first day of our visit one person who had arrived later was left without food for 10 minutes and was in conflict with people at either side of them who were eating.

We noted not everyone requiring support and encouragement to eat were given this time. We saw one person drinking from another persons’ cup and we saw meals taken away that were not eaten and their drinks left. Two people were asked what they would like much later during the meal, after refusing to eat their dinner and they were provided with a sandwich. One person was not given a drink with their sandwich until much later when we requested this. We overheard one carer asking where the pudding was as people were restless. We observed a visiting relative encouraging one person to eat their pudding. Another person was still sat at the table at 2.20pm having eaten a small portion of their meal and was pulling at the table and banging their glass shouting, ‘mother, mother’. The atmosphere at meal times throughout our visit was not relaxed. However we noted staff who did provide support to people chatted amiably to them throughout the meal. We saw these people were being sensitively supported and encouraged to eat their food.

Care records included information about people’s dietary preferences and any risks associated with their nutritional needs. This information had been shared with kitchen staff. People’s weight was checked at regular intervals and appropriate professional advice and support had been sought when needed. However we saw one persons’ hospital discharge assessment that indicated that they were on supplementary drinks and forticreme [fortified]

deserts. This information had not been acted upon on admission to the home despite this being queried by a staff member and daily evidence of a poor dietary intake. We saw examples where staff were instructed in care plans to make sure people had plenty of fluids that included one person at risk of a urinary tract infection. We checked fluid and food intake charts on the second day of our visit to see how accurately these had been completed. These did not reflect an actual account of nutritional or fluid intake we had observed. Failing to effectively monitor people's nutritional intake places people at increased risk of poor health.

The provider had failed to ensure that the nutritional and hydration needs of people using the service was adequately met. This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three people using the service were receiving their nutrition via a PEG (percutaneous endoscopic gastrostomy). This is used for people who are unable to swallow or eat enough and need long term artificial feeding. Nursing staff provided this support and the prescribed feed contained all the calories and other essential nourishment such as vitamins and minerals that people needed.

We looked at how the service trained and supported their staff. We asked one staff member about their induction training. They told us they had spent an hour shadowing another more experienced staff member. They told us they had worked in a care environment before and so were familiar with the work that was expected of them. They were aware of policies and procedures but had not read them yet. We looked at induction records. These showed staff were provided with a basic introduction and overview of the service. From our discussions with staff and from looking at individual training records and the training matrix, we found staff had access to a range of appropriate training. Regular training included safeguarding vulnerable adults, moving and handling, fire safety, infection control, first aid, food safety, health and safety and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However some of this training had taken place some time ago and refresher training had not been provided. Some staff had achieved a recognised qualification in care.

Other training that would provide staff with essential skills in key areas such as, person centred care, care planning and record keeping, stoma and catheter care, diabetes, end of life care and stroke awareness had not been provided, although this was identified as a training topic on the training matrix. During our visit a trainer arrived at the home to give senior staff training in PEG feeds, but no-one was available to take part in the training as they were fully engaged in care delivery. This training would help to make sure staff were confident, safe and competent to provide people living with these conditions with effective care. One staff member told us that although they received some training and support they needed, they felt they would benefit from more training such as dementia care. There was a range of policies and procedures for staff guidance although staff we spoke with told us they did not have time to read them.

Staff told us they were supported by the registered manager although records showed there were gaps in the provision of formal supervision sessions. Not all staff had received one to one support which meant shortfalls in their practice and the need for any additional training and support may not have been identified. The registered manager was aware of the gaps in the provision of supervision sessions for some staff. She had started these and the plan was under review as the deputy and seniors were to support her to provide this level of support. We looked at a random sample of completed supervisions which were thorough. However we found instances where staff had a reactive supervision due to performance issues and these had not been followed through with competency assessments and follow on supervisions in order to monitor their practice

The provider had failed to make sure staff were given appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had handover meetings every day. Records showed a brief was relayed for each person using the service at the start of shifts. Information recorded was minimal for example, legs red, poor diet, started antibiotics, in bed all day, catheter draining. We were told by the registered manager these issues would be discussed

Is the service effective?

with staff in more detail, but when we asked staff about the various issues raised at the handover, they were not familiar with these. When asked, a staff member did not know the surname of the person that they were going to help and did not know which room the person had come from. Staff told us they did not always read people's care plans and were unfamiliar with some aspects of peoples care. Staff told us, "If we need to know anything the senior or the nurses tell us." And, "We are very busy and we don't have time to read care plans. Charts are completed at the end of the day by the nurse or senior." And, "I've not been here long, although I do have experience in care work. I never get a care plan or instructions so I ask other staff if I'm unsure what to do. They seem to know what they are doing. The seniors will listen to staff." "I haven't worked here long and I love the work. More continuity is needed."

We asked people using the service if they were involved in planning their care and support. People told us, "Staff do have care plans. Mine is just being done. I do read it when I want to." Another person told us, "I've not been involved in a care plan." And another person told us, "I haven't read any notes on my care but staff do ask me what I want." We spoke with relatives. They told us "I've been to a care plan meeting where I've been asked about my relative's needs. My relative's needs have recently changed but I haven't been informed if the care plan has been updated." Another relative told us, "I haven't seen any care plans but they might have asked me questions about my relative."

We looked at six care plans and associated documents. We found there was generally limited information recorded. Risk assessment forms inside were not always complete. The pages were set up with forms in the format that the file was going to take, but these showed no or limited information was in most files. The registered manager showed me one completed care plan that was well written and person centred.

We looked at how people were supported with their health. We found people's healthcare needs were considered during the initial care planning process and as part of ongoing reviews. We noted staff were instructed to be 'aware of signs and symptoms' of medical conditions documented in people's notes. However there was no information provided for staff to support them in understanding signs and symptoms of various illnesses. Records had been made of healthcare visits, including GPs, district nurses, dietician, continence advisor and the chiropodist.

The service provider had failed to make sure people's care records were complete, accurate and updated. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service had good links with other health care professionals and specialists to support people's healthcare needs. A visiting health professional told us they had been to the home many times and seen many changes. There was always a staff member to assist if assistance was required and "no concerns had been observed". The paperwork that was required whenever a visit was undertaken was always available. Another healthcare professional visiting told us, "Staff are hardworking but sometimes they don't work as a team. It seems to be up and down with care. Agency staff don't always know people. There are some good carers."

The responsibility for overseeing people's care was divided into two groups, nursing and residential. Staff were unsure why this practice was followed, but that "it had always been this way". Each group of staff responsible for overseeing people's care appeared to have limited knowledge about each other's group of people using the service. Without the relevant knowledge staff might not necessarily be aware of any deterioration of people's health and take preventative action at the right time to keep people in good or the best of health.

The provider had not ensured that staff were kept up to date with the changing needs of people using the service. This was a breach of regulation 9 (3)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions were protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this. The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The service had policies in

Inadequate

Is the service effective?

place to underpin an appropriate response to the MCA 2005 and DoLS. The registered manager expressed a good understanding of the processes relating to MCA and DoLS. Staff had received training in this subject.

At the time of the inspection applications for DoLS had been made which would help to ensure people were safe and their best interests were considered. We did not however see any supporting evidence to show a mental health capacity assessment had been completed to support the application. Furthermore there had been no mental capacity care plan or record of restrictive practice written down which gave adequate reasons as to why restrictive practices had been adopted. We noted two people were in a reclining chair for long periods and that this restricted their movement. There had been no 'best interest meeting' to justify and show how this was the least restrictive option for these people.

During our visit we observed people being asked to give their consent to care and treatment by staff. Staff spoken with were aware of people's capacity to make choices and decisions about their lives. This was not always clearly recorded in the care plans, for example, we saw one person walking around barefoot. Staff told us this was the persons' choice and the care plan reflected this information. However following a recent change to the clinical requirements of this person, we did not see a review of the situation or best interest discussion initiated about the person. This would have established whether or not it was in the person 'best Interest' to continue doing this and whether the decision made was an informed decision.

White Ash Brook is a purpose built home with accommodation facilities on the ground floor and office facilities and staff room on the first floor. The gardens were safe and secure with adequate garden furniture. People told us they were happy with their bedrooms and some had created a homely environment with personal effects such as furniture, photographs, pictures and ornaments. People told us, "There is enough light in my bedroom in the evenings for me to do things. It's a nice room." All bedrooms were single occupancy with en suite facilities.

We recommend the service finds out more about training for staff, based on current best practice, in relation to clinical risk assessment and management and positive risk taking.

Requires improvement

Is the service caring?

Our findings

People who we spoke with told us they staff were "kind" and "caring". They described staff as being "very busy" all the time. Comments included, "They do their best under the circumstances. I can't grumble really." "I'm all right. I get my meals and help me when they can. I only have to ask." "The staff are polite and kind. When I go to hospital appointments staff accompany me and sit and chat with me." "They seem to like me and nobody has ever been nasty to me." However people considered staff did not have time to get to know them. Comments included, "Staff don't have time to talk to anybody. Staff don't sit and talk to me, but they would come over if I asked for anything. Staff are very good really." And "Staff don't have time to talk to residents. I'm a chatty person and would love to have a general conversation."

We asked people if staff respected them and maintained their dignity. Comments included, "I get well looked after", and "Staff let me move around in my wheelchair. I can please myself when I get up and when I go to bed. Staff help me pick what I want to wear for the day." "I decide what I want to wear. Staff look after my clothes. Occasionally I have been given other people's clothes to wear which I refuse." "I would like to have a shower every day but I know that the staff are too busy." People told us staff always knocked on their door before they came in.

Following observations throughout the day, the care delivered appeared to be given with kindness and compassion. Staff did show concern for people's wellbeing but also appeared to be focused on delivering tasks. We observed staff approach people in a kind and friendly manner and being respectful of people's choices. Staff took time to listen to people when they were supporting them.

Before this inspection we had received concerning information that staff were unable to give people the care they needed. We had been told 'My concern is that standards of care cannot be met and the people in our care deserve much, much, better'. And, 'It is an impossible task and needs are not being met, or high standards of care being given which is distressing to me personally, and unacceptable under my code of conduct'. This was a concern expressed by staff we spoke with. One staff member told us, "I think the carers are incredible. They are put through stress every day, although they will always put the resident above themselves." Another staff member told us, "I am concerned people don't always get the help they need. Training tells you to spend time talking to people and make their care and support personalised. We just don't always have the time to do that." And another staff member told us, "Personally I do not think there is enough staff and I think every day residents' needs are not being met. I think both carers and residents are suffering because of this." We observed one staff member who started their shift at 8am having their lunch at 4pm. When we asked them why they were late we were told, "I couldn't just leave people. It's been really busy."

We observed people's dignity being compromised on several occasions during our visit, particularly with people who could not attend to their own needs independently. For example we saw one person pushing themselves away from the table several times without eating their meal and, as staff walked past, the person was pushed back to the table without any exchange of dialogue. One person was observed wearing a urine stained nightdress over a skirt throughout the first day of our visit. On the second day of our visit the same person had a cardigan fastened around their waist under their skirt with the arms of the cardigan visible below skirt level throughout the day. On five of the six days this person was inappropriately dressed. We saw people with footwear on the wrong feet and one person had odd slippers on, on two separate days. The care plans for all these people demonstrated that they required staff supervision to assist them when they were getting dressed.

We looked in care records and we could not find any reference to people's preference to gender of carer. We could not find records to show people had regular baths. Some daily records did identify an occasion when this had happened but there appeared to be no structure around bathing people. We observed people were not given the level of supervision they needed to attend to their personal care. For example we saw attention had not been given to some people's appearance. Some people's hair looked like it had not been washed or brushed and when people finished their meal they were not offered hand or face wipes to clean themselves. We saw one person who had very dirty feet with long nails and two people had noticeable dirty fingernails. In one bedroom we saw spectacles and part denture on a bedside locker belonging to a person dependent on staff support for personal care. Staff were instructed to make sure this person had their glasses on and hearing aid in, but when asked, staff did not

Requires improvement

Is the service caring?

know they wore them. We asked staff to look at this issue on three separate days because this person still had not been assisted by staff to ensure they had their glasses on and hearing aid applied.

We visited one person who was in bed because they had a pressure sore in evidence. They were distressed and shouting. There was dried food on the side of their mouth which had not been removed once the staff member had assisted them to eat their meal. A member of staff told us the person had been on end of life care but had improved and was taken off this status. We asked why the person was in a room so far away from carer attention and was told that "she disturbed other people by her screaming". We observed that this person was distressed during the day due to symptoms of her condition and often heard her shouting for long periods of time. Due to the fact that she was located so far from the central areas of the home she was isolated and staff could not readily intervene to alleviate her distress and provide comfort.

Relatives and friends were able to visit without being restricted. We spoke with relatives visiting regarding people's general care, visiting arrangements and attitude of the staff. Two relatives we spoke with told us they visited every day. Staff were very good and they could make themselves a drink when they wanted one. One relative told us, "Staff are wonderful" and that they felt supported and listened to. Another relative told us, "My relative is kept clean and tidy but sometimes she could do with a hair wash. There is a hairdresser comes every week but her hair does look unkempt at times. She does sometimes have the appearance of being unloved and uncared for. I have complained to the manager but again this comes down to staffing levels." Other relatives commented, "There are too many new staff who do not know the needs of individual residents. The vast majority of care staff makes me welcome." They went on to tell us that not all staff did. Another relative said, "I have observed some good levels of care for both my relatives residing in the home despite serious staff shortages and have been very grateful for this."

The service provider had failed to ensure that people's right to dignity and respect is maintained at all times. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People who used the service told us they felt confident they could raise any concerns with the staff or managers. One person said, "I'd speak to one of the carers if I had a problem and they would try their best to put it right." Another person told us, "If I had a problem I'd complain to the manager. I haven't made a complaint to her, but I have complained to the area manager about the food. New menus have been started just this week." A relative we spoke with said, "I speak to the manager if I have any concerns and I am listened to." Another relative told us "I know staff would like to spend time chatting with residents but they just haven't got the time and residents suffer as a consequence of this. I have complained to the Head Office of the organisation but haven't seen any noticeable improvements in staffing levels." Another relative told us, "I have told staff about my relative's care needs but they don't do much about it. For instance I've asked them about a shower but it just doesn't get done."

There was a complaints procedure displayed in the home. Staff, residents and visitors spoken with did agree that they all understood how to complain and that they would be happy to report this to the manager. However we found that when complaints had been made by relatives these had not always been documented and dealt with formally so complainants were left with no resolution to their concerns.

In the past 3 months we have received information of concern on three occasions about the service in relation to care, management and staffing. During the inspection we found shortfalls in the provision of staff, the care that people received and in the management of the service.

We looked at pre admission assessments and noted before a person moved into the home an experienced member of staff had carried out a detailed assessment of their needs. Information had been gathered from a variety of sources such as social workers, health professionals, and family and also from the individual. The assessment covered all aspects of the person's needs. The assessments were basic and included information about the person's care and welfare needs and mental capacity. This provided staff with some insight into people's health and social care needs. When admissions were planned people were able to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed people to experience the service and make a choice about whether they wished to live in the home.

Emergency contact details for the next of kin or representative were recorded in care records as routine. Some relatives told us they were always contacted if there were any significant changes to their relation's needs. However during our visit one relative was very upset as they had not been told of their family members change in health overnight. This was a significant event which warranted clinical oversight. Arrangements had not been made by the staff at the home to obtain immediate medical assistance and this was only undertaken once the relative brought the matter to the attention of the manager.

Each person had a care plan that was personal to them; however we found some elements of these were not completed. The registered manager told us they were in the process of transferring information from the computer to paper files. We saw that where there were changes in people's needs and this was not always identified. We looked at the details of a fall that had resulted in a person sustaining significant bruising to their face. The care plan did not have an assessment for mobility or falls despite information provided to the service they were at risk, and had a history of falls. Following the injury, the persons' needs had not been reviewed. The same person required plenty of fluids but there was no evidence this was monitored adequately or action taken to improve the persons' fluid intake. We had observed drinks the person had left at lunch removed by staff. We saw no action taken despite evidence in records of poor fluid intake. An indication of dietary supplements needed on a hospital transfer assessment had not been followed through with the persons GP, and the person did not receive any. We also saw examples where people's needs were observed during our visit as not being met, and records we looked at in relation to these needs offered no action plan to address the situation. One person had what looked like faeces between their toes. We could not find when this person was last bathed and although the care plan referred to the person attending chiropody services regularly this had not been arranged as planned.

Communication was not good in ensuring all staff working in the home had enough information to respond to people's changing needs. There was no evidence to show

Inadequate

Is the service responsive?

that charts used to monitor people's care had been reviewed at regular intervals to ensure any necessary action required, was reflected in care plans. Whilst work had been undertaken to transfer care planning information to a paper based system staff told us that the new care plans were not looked at as a means of gathering information to deliver care. Staff relied on transferring information verbally between each other which led to important care being missed or information not being acted on in a timely manner. This was an issue particularly due to the fact that there was not enough staff available at the home coupled with a high reliance on agency staff and a high turnover of staff. These factors placed people at risk of inconsistent care or not receiving the care and support they need.

We noted that one person was unable to get out of bed due to his medical condition. He had been assessed some months ago by an occupational therapist for a specialist chair so that he could sit in the lounge and help with his isolation and promote his well-being. Despite this assessment the chair had not been provided by the service provider even though the manager had repeatedly asked that this be provided since April this year. This had led to this person remaining in bed unnecessarily for a number of months. Following our inspection we have been told the chair is now ordered however there are other people in the home where specialist seating has been advocated for use and where this still has not been provided.

The service provider had failed to ensure that care was delivered in a person centred way which met their individual needs. This was a breach of regulation 9 (1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about activities in the home. People gave different accounts of their experience. One person told us they loved the bingo sessions. Another person told us, "The activity coordinator has recently joined the staff and has asked me what I'd like to do. We did go to the pub across the road but we haven't been there this year because there's no one to drive the mini bus. The mini bus belongs to the home but it isn't used anymore." Another person told us, "I have been on coach trips occasionally." And another person said, "We do have quizzes and bingo sometimes which I like, I enjoy them. We have them about once a week." We observed people reading, watching television and one person using a personal computer in their room.

We noticed there was a programme of activities displayed for the week. We spoke with the activity co-ordinator about the activities people were involved in. We were told there was a variety of activities on offer. "I get £100 per month to spend on entertainment and equipment from the company. I try through activities to give one to one sessions with residents. I keep files of all individual residents in the home including any day to day activity done with individuals or groups. The administrator did my job before me and she has helped me tremendously. I've trained myself by picking her brains. I feel I would benefit from some dementia training. I have done basic dementia training, but it didn't include skills such as communication with dementia."

Inadequate

Is the service well-led?

Our findings

There was a registered manager in day to day charge of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The registered manager was supported by a deputy manager and area manager employed by the company White Ash Brook (Accrington) Ltd which is a subsidiary of Astonbrook Care Ltd. The registered manager had been registered with the Commission since 8 September 2014 and transferred this registration when White Ash Brook (Accrington) Ltd were registered in April 2015. We were informed by the manager that she had taken the decision to resign from her position and at the time of the inspection she was working her notice.

People we spoke with had mixed feelings regarding how well the home was run. One person told us, "I don't know who the manager is. The staff seem happy here." Another person said, "I'm not afraid to complain. I don't think the home is well run." A relative told us "I know who the manager is and can approach her with any difficulties. She does know the residents but she has a lot of new staff to deal with." Staffing levels was a major concern with people we spoke with. One relative said "I think the owners have a responsibility to properly staff the home." Another relative said, "There are some really caring staff who have had to leave because of the conditions of work here."

We looked at comments relatives made in a quality audit survey. These included, "Staff are very good and have a good relationship with mum in general. I am very happy with mums care." "Staff are friendly and helpful".

We asked staff if they thought the service was well led. It was very apparent that some staff were unhappy with how the service had been managed for a number of months. Staff did not feel their concerns were taken seriously by the service provider and that issues they raised particularly around staffing levels were ignored. We heard comments such as, "Things are not good" and "no confidence", expressed. We also heard of "some long standing problems with staff not co-operating" and "leadership questionable" A member of staff told us, "It can get a bit troublesome when both manager and deputy are absent. It has happened quite frequently in the last few months. Also the deputy manager is taken to do medication rounds and working on the floor on twelve hour shifts as a senior carer. I think there needs to be more support to voice concerns." Another staff member described the situation in the home as "a rudderless ship".

We were concerned that on the first day of our inspection there was no management presence in the home. The registered manager was on annual leave and the deputy manager had been rostered on duty to provide nursing cover. The Deputy manager did maintain a professionalism to attend to the requirements that a qualified nurse needed to provide to people with nursing care needs. This made it extremely difficult for her to act in a managerial role to support the inspection which we acknowledged and understood. On the second day of our visit we were also concerned the deputy manager did not have access to documents we requested and was not as familiar with the general running of the home expected for a person in her position. The service manager who was present on the second day of the inspection was also unable to access information we required. This meant in the absence of the registered manager, the deputy manager could not fulfil her role and was therefore not provided with the full support she needed to manage the home effectively. Furthermore on another day of our visit the registered manager and deputy manager were rostered on care and nursing duties for the day and were limited in offering us support to complete the inspection.

We had received concerning information in relation to the level of staffing and the impact this had on people living and working in the service. Our records showed there had also been twelve safeguarding alerts forwarded to the Commission since May 2015. These were in relation to a medication error, altercations and assaults between people living at the service, serious injury and poor care practice. We looked at emails sent to senior officers within the company from the registered manager highlighting concerns around staffing issues. We had also received concerns during our inspection that despite our findings there would be no more staff provided. We noted in one email sent to a senior manager in the company, the registered manager had pointed out staffing calculations were not correct. This was however dismissed by a senior representative of the company. Whilst we asked how decisions were reached about the number of staff on duty during the day and night time hours no satisfactory answer was given. The dependency needs of the residents had not

Inadequate

Is the service well-led?

been taken into consideration whilst making these decisions. This was concerning and gave us no faith that the issues we had identified during this visit was taken seriously enough to improve the service.

We found that staff were aware of their responsibilities and their duty of care and were eager to provide quality care for people. Staff told us they stopped at the home because they liked the people who lived there and wanted to do their best for them. However the serious lack of staffing compromised their ability to provide care in a timely and consistent manner.

Staff supervision was not provided regularly and when it was undertaken it was generally as a response to a failure to meet standards expected by the registered manager and the company. We found where incidents had occurred there had been no follow up monitoring of staff's performance. For example we saw incidents dealt with under supervision following medication errors. We did not see any evidence of any follow up supervision or competency checks having been carried out.

We noted training that would help to reduce risk of any error occurring such as training in administering of medication via PEG, was not formally provided. We spoke with one nurse who told us there were three people with a PEG. They had been shown by another nurse how to give medication via this route but they did not feel entirely confident doing this, although the nurse giving the instruction had showed them several times. We saw staff with issues around poor care practice had not been managed properly. There was little accountability for staff practice as basic care issues we identified as lacking during our visit, had not been recognised or addressed. This meant there was a failure to make sure care and support provided to people was guided by good practice and management support.

It was not clear who took the lead in safeguarding concerns or clinical incidents and also who would be the lead to communicate with external agencies such as the Local Authority, Clinical Commissioning Group's (CCG) and take a clinical lead in the communication with these agencies. We were told the manager would manage any complaints made. We looked at the complaints book. There was one formal complaint that was under investigation. Relatives were telling us that they had raised concerns and made complaints however it was evident that these had not been formally acknowledged and therefore there had been a lack of response to issues raised.

Risk management of both clinical risks and managerial risks inclusive of environmental issues did not seem to be one of prevention or learning from incidents, but one of dealing with an incident when it happens. Whilst limited quality auditing was carried out it did not show how this was improving people's care. We saw for example a weight gain and loss audit which had not been updated since February 2015. Improvement required in the delivery of care for particular people considered at risk, was not being adequately monitored.

A formal accident book was in place but was not being routinely completed by staff. There had been no managerial oversight of accidents and incidents in order to identify patterns and trends and develop appropriate interventions where any risks had been identified.

The providers Policies and Procedures had not been available in the home until very recently so staff had not had these to refer to for guidance. It was noted that some of the Policies and Procedures were very limited in content such as those related to infection control, skin integrity and nutrition.

It was noted that the Company operating the home had appointed an external company to undertake quality monitoring at the home. A quality monitoring audit was undertaken in August and identified some issues which required urgent attention. The manager told us that she had not been provided with a copy of the report or had received any feedback from the senior management team to enable her to address the issues identified. The registered provider had not introduced strategies, to minimise identified risks to make sure the service runs smoothly. Additional issues of concern were identified during this inspection. We would expect such matters to be identified and addressed without our intervention.

The provider had failed to have suitable arrangements in place for assessing and monitoring the quality of the service and then acting on their findings. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider has not made sure there was enough staff deployed to ensure people's needs were met. Regulation 18 (1)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person has not made sure people who use services were protected against the risks associated with unsafe management of medicines. Regulation 12(2)(a)(c)(g)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person has not made sure people were protected against the risk of infection. Regulation 12 (2)(h)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person has not made sure people were protected from unsafe care by identifying and managing risk to people's health and welfare. Regulation 12 (2)(b)(c)

The enforcement action we took:

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person has not ensured people requiring support and supervision for nutritional and hydration needs received this. Regulation 14 (1)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that staff received such appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider has failed to make sure people's care records were complete, accurate and updated. 17(2)(c)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person has not made sure staff were familiar with people's changing needs. Regulation 9(3)(g)

The enforcement action we took:

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person has not made sure people had their dignity maintained at all times. Regulation 10

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person has not ensured people's needs were effectively planned for and made sure staff had good knowledge of people's needs. Regulation 9 (1)(3)(a)(b)

The enforcement action we took:

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person has not made sure people who use services, and others, were protected against the risks associated with ineffective processes to assess, monitor and improve the service. 17 (1)(2)(a-f)

The enforcement action we took: