GB Care Limited

Acorn Hill Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced, comprehensive inspection on 31 July 2018. The previous comprehensive inspection of the service in June 2016 rated the service as Good. This was followed up by a focussed inspection carried out in March 2017 in response to concerns about people's safety. The service remained rated as Good. At this inspection we found improvements were needed to ensure people received safe, effective care that met their needs.

Acorn Hill Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service accommodates up to 59 older people in one adapted building. Some of the people using the service had complex physical and mental health needs and many people were living with dementia. At the time of our inspection there were 40 people using the service.

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

People were not always protected from the risk of infection. Procedures and systems were not effective in preventing the risk of infection.

The premises were not consistently well maintained or assessed to prevent potential risk of harm for people.

Risks to people were not always assessed in a timely manner. Records lacked clarity in providing guidance for staff on the measures they needed to take to keep people safe.

The management and monitoring of people's wounds was not safe or effective in protecting people from the risk of infection or prevent further deterioration of wounds as far as possible.

Improvements were needed to ensure people's medicines were stored and administered as prescribed.

The registered manager undertook a range of audits and checks to monitor the quality of the service; producing action plans to identify and address where improvements were required. We found these had not been effective in identifying the areas of concerns we found.

There were insufficient arrangements in place to ensure sufficient numbers of staff were always deployed in response to unplanned staff absence, although sufficient numbers of staff were available on most

occasions.

Staff told us they had completed a range of training to give them the skills and knowledge to provide effective care and this was evaluated during regular supervision. Training records were not fully completed or kept up to date to support the effective monitoring of staff training.

People's care and support needs were not always effectively monitored and reviewed to ensure care was provided in the way they needed. People were supported to eat and drink. However records did not reflect people were always protected from the risk of poor nutrition.

The premises did not fully support people to engage with their environment or support them to orientate around the building. Improvements were needed to ensure people were provided with meaningful activities that engaged and stimulated them and provided them with a sense of purpose.

Care plans were personalised and supported staff to provide personalised care. There were limited opportunities for people and their relatives to be involved in their care planning or to share their views about the service.

The provider had systems to manage any complaints they received. Although people and relatives knew how to raise concerns, they were not confident that improvements would be made or sustained as a result.

People felt safe when they were receiving care from staff. Staff understood their roles and responsibilities to safeguard people from the risk of harm.

Staff were appropriately recruited. Checks to ensure they were suitable to work with people had been completed before they started work.

People were supported to make decisions and choices about their care. Staff understood the principles of the Mental Capacity Act 2005 and sought consent before providing care and support.

People described staff as being kind and caring. Staff had developed positive relationships with people through effective communication. Staff addressed people with respect and protected people's right to be treated with dignity and have their privacy protected.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Robust systems and procedures were not in place to protect people from the risk of infection.

Risk assessment records were not always updated in a timely manner, and did not always provide the detail guidance staff needed to keep people safe.

Improvements were needed to the storage, management and administration of medicines.

Staff had an understanding of what abuse was and their responsibility to act on concerns. The registered manager was in the process of taking action to ensure there were always sufficient numbers of staff deployed to keep people safe and provide care in a timely manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Records did not support the effective monitoring and reviewing of people's health needs, including nutritional needs, to ensure their health and wellbeing was maintained.

Staff were supported through a programme of training and supervision

Staff understood the principles of the Mental Capacity Act 2005, including gaining consent to care and people's right to decline care.

The premises were not effective in supporting people to engage, interact and move around the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always have the time to provide the care people

needed in a timely manner.

People and relatives though staff were kind, caring and knew people well.

Staff protected people's privacy, dignity and confidentiality and were respectful to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Reviews of people's care records did not always reflect people's current needs or evidence that people and relatives had been involved in reviews of their care.

People had access to an activities programme. This required review to ensure staff had the support and skills they needed to create meaningful, stimulating activities for people.

The provider had a system in place to receive and monitor concerns and complaints, although this was not always effective in bringing about improvements in the service.

Is the service well-led?

Requires Improvement

The service was not well-led.

Arrangements to monitor and evaluate the quality of the service were not effective in ensuring people received good, safe care.

There were limited opportunities for people to share their views about the service.

Staff spoke about positive teamwork and had a clear understanding of respecting equality and diversity within the service.

Acorn Hill Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 31 July 2018 and was unannounced.

The inspection team consisted of two inspectors, an assistant inspector, a specialist nursing advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included notifications of significant events and incidents within the service that the provider is required to tell us about by law. We also reviewed information provided by commissioners, responsible for funding and monitoring the care and support of people using the service. Our review of this information enabled us to ensure we were aware of, and could address, any potential areas of concern.

During the inspection we spoke with ten people and six relatives of people who used the service. We also spoke with the registered manager, the deputy manager, two registered nurses, three care staff, two domestic staff, the activity co-ordinator, the cook and a visiting pharmacist. We observed care and support provided in communal areas and the lunchtime meal. This helped us to evaluate the quality of interactions and support that took place between people and staff who supported them.

We looked in detail at the care records for eight people. We sampled medicine records and reviewed five staff recruitment files. We also reviewed records relating to the day-to-day management of the service, including records of meetings, complaints and staff rotas, and the provider's internal audits and quality management systems.

Following our inspection, we asked the registered manager to provide us with further information pertaining to staff training. They did this in a timely manner.

Inadequate

Is the service safe?

Our findings

People were not always protected by the prevention and control of infection. There were strong malodours in some areas of the service and some corridor carpets were badly stained. Toilets and bathrooms required deep cleaning to remove stained grouting and replace sealant around the edges of showers and baths; these areas were in need of re-decoration. Waste bins in bathrooms were overflowing with waste and, in many cases, were broken or raised off the floor so the foot pedal could not be used. The sluice room, allocated to manage soiled waste, was unlocked and we found the sink to be dirty and stained. Floor tiles in the laundry room were damaged and cracked, hampering effective cleaning. There was debris and dust in the clean linen room. Skirting boards were dusty in communal corridors and some armchairs in lounges were dirty and stained. We found clinical waste had been disposed of in an open general waste bin in one lounge.

There was a member of staff who oversaw domestic standards within the service. They were knowledgeable about infection control, the products and methods to be used and told us they worked to cleaning schedules each day. They provided us with room schedules, which detailed areas that needed to be cleaned, methods to be used on a daily basis, and deep cleaning schedules for furniture and fittings. We looked at daily cleaning charts for a bathroom on the first floor. We found gaps of up to five days between entries, which indicated the area may not have been checked or cleaned on a daily basis.

The staff member responsible for laundry demonstrated they were knowledgeable about safe procedures, including the management of soiled linen. However, we found detergent bottles in the laundry area were not stored safely in a lockable facility. An internal audit undertaken in June 2018 had identified this as a concern, but no action had been taken.

Staff were observed to wear appropriate personal protective equipment when supporting people, for example gloves and aprons. However, these were not available in some bathrooms and toilets. We found some hand sanitizer units in communal areas were empty.

The premises were not always well maintained and, in some instances, posed a risk to people. For example, pipe work to radiators was exposed and had not been boxed in. This could present a risk of scalding if pipework became hot. The provider had installed a safety gate at the foot of the ground floor stairway to reduce the risk of people using this area unsupervised. However, we found stairways to the first and second floor were open and accessible, with a low bannister. There was no evidence that the provider had assessed these areas to determine potential risks of people using the stairways unsupervised. We found several fire doors were held open by chairs, including people's rooms.

People were routinely protected from the risk of fire and equipment failures by a range of health and safety checks that were routinely undertaken. Records relating to checking and testing equipment provided evidence that routine maintenance was carried out on the lift, hot water and utilities to ensure people were kept safe. However, we found there were occasions when lapses in routine checking had occurred and people could not be assured that all equipment was in good working order. For example, nurse call points

throughout the premises were usually checked monthly. At the time of our inspection, more than a month had passed since the previous check, where two call points had been found faulty. Records did not show if theses faults had been reported or appropriate repairs undertaken. Staff were unaware of the faults and were aware of people using the rooms were able to summon assistance from functioning call points. When we checked the rooms, the call points were in working order but these repairs had not been followed up or recorded as a clear audit trail.

Records identifying and assessing the potential risks for people required improvement. Care plans contained risk assessments for areas such as falls, mobility, skin integrity and nutrition. We found records did not always include the detailed information and guidance staff needed to keep people safe from harm. Risk assessments were not always reviewed or updated in a timely manner. For example, one person's risk assessments had not been completed until one week after they started to use the service. Their assisted moving risk assessment was not completed until seven days after admission, despite the person having a history of falls and serious injury. Their assessment for skin integrity had not been completed until seven days after admission, despite the person being admitted with a serious pressure ulcer. A second person had more detailed risk assessments, but these lacked specific guidance for staff. For instance, their assisted moving risk assessment listed equipment to be used, but did provide guidance for staff as to the size of slings to be used or how staff should support the person using the equipment.

Records did not always support the effective monitoring of people's health needs. Wound care plans did not support staff to identify when wounds improved or deteriorated, or confirm staff were providing care in line with professional guidance. Care plans did not always include a photograph of the wound and the site of the wound was not written on the photographs that were in place. Wound assessment charts showed measurements of the wound, although there were no systems to ensure measurements were taken accurately rather than 'best guess'. Information in people's care plans and wound assessment charts was inconsistent and was not always completed to evidence that wounds were dressed in accordance with professional guidance. For example, one person's care plan advised nursing staff to 'change dressing daily'. The registered managers' monitoring records stated 'dressing changed PRN' (when required). The last entry on the person's wound assessment record was dated two days before our inspection visit. A second person's care plan instructed nursing staff to 'change dressing every third day'. The last recorded dressing change was dated 11 days before our inspection visit. A third person had an advanced pressure ulcer. Her care plan did not include a photograph of the wound and there was no wound assessment chart in place. Some of the wounds were at risk of deteriorating rapidly and were at high risk of infection.

We had received a number of safeguarding concerns around the management of people's wounds, including concerns from health professionals involved in people's care. A relative told us they had concerns that staff had not taken appropriate or timely action to reduce the risk of their family member developing pressures ulcers. When they did develop pressure ulcers, the family were not told until the ulcer had deteriorated significantly. This evidence supports our findings that the management and monitoring of wounds did not ensure that wounds were effectively or consistently managed.

Improvements were needed to the storage, management and administration of medicines. The temperature of the medicines room and fridge were not regularly monitored. We found gaps in recordings throughout July 2018. On two occasions the temperature of the storage area had exceed 25 degrees celsius. Records did not demonstrate actions staff had taken to reduce risks. Some of the prescribed medicines in use, for example supplements, required storage at a lower temperature to maintain their integrity. Fridge temperatures had exceeded the recommended safe range on four occasions. Staff told us they had reported this to maintenance staff.

Oxygen was stored in the clinic room and there were appropriate warning notices displayed to advise staff in the safe management of this. However, one person who used continuous oxygen, did not have any warning notices in their room to advise staff and visitors of the measures they needed to be aware of to reduce potential risks.

Medicines kept in stock were in date; however, liquid medicines were not always dated when opened. It is good practice to write the date of opening on these medicines as many have a short shelf life.

Records were not sufficiently detailed for people who received their medicines through transdermal patches (patches applied directly to the skin). Rotation charts were in place showing the administration site. This is important to avoid sensitivity or skin irritations occurring. However, there were no records to evidence that patches were checked daily to ensure they remained in situ. One person's records showed that on two dates, the previous patch could not be found. The person may not have received the full dosage of their medicines; records did not demonstrate any actions staff had taken in response to this.

The service did not have a robust system in place to ensure that a safe period of time was observed between administration of medicines. Staff began to administer the morning medicines at 9.15am and this was completed at 11.30am. Staff then started to administer lunchtime medicines at 12.47pm. This presented a potential risk that staff were not leaving sufficient time between doses of medicines in line with manufacturer and pharmacy guidance. The registered manager told us they would review administration times and implement strategies to address these concerns.

These matters constituted breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of managing and administering medicines were safe and demonstrated staff were following best practice. For example, people's medicine records including a current photograph, details of any allergies and how they like to be supported to take their medicines. We saw people were supported to take their medicines in line with their preferences. Staff spent time explaining to people what their medicines were for and gave people the time they needed to take their medicines. Where people were prescribed medicines to be taken as and when required [PRN], these were supported by detailed protocols to guide staff when and how to administer. People who experienced pain were assessed using the Abbey pain scale. This demonstrated staff were following best practice in using formal assessment tools where people experienced barriers to communicating their pain.

Some people received their medicines covertly (disguised in food or drink). Records showed best interest processes had been followed and relevant authorisation obtained from the GP, which had been regularly reviewed. Records required further development to reflect pharmacy advice had been sought as to the suitability to disguise medicines in the manner proposed, and identify risks if the person declined to consume the food or drink. A visiting pharmacist told us they were working with staff to bring about improvements in the management and administration of medicines, which were in progress.

People and relatives told us they felt safe using the service. One person told us, "I feel safe living here and I can do what I want. The staff pop in to check if I'm am okay." A relative told us, "They [staff] do look after [name] 24/7."

Staff understood how to protect people from abuse and harm. They were confident about how they would report any allegations or actual abuse. One staff member said, "We can raise any concerns with managers; we have weekly meetings to discuss people's safety and safeguarding. There is a telephone number in the

staff room to support staff to whistleblow (raise concerns about potential malpractice in the service with relevant external agencies)." The provider's safeguarding policy included current guidance and best practice for staff to follow. Staff told us they had completed safeguarding training.

Information we held about the service informed us that the service had experienced a high volume of safeguarding alerts in the last 12 months. These related to standards of care, governance and poor reporting. The registered manager was aware of their legal responsibilities to notify external agencies, including the CQC, of any potential incidents where people were at risk of or had been exposed to harm. They worked with external agencies to decide on the best intervention to keep people safe.

People and their relatives told us they felt there were usually enough staff to meet their needs. One person told us, "I think there are more staff here in the week than there are at weekends. You don't usually have to wait long (for help)." A relative told us there were always staff around when they visited at various times. Staff told us there were usually enough staff, but experienced problems with unplanned staff absence. One staff member said, "There are usually four of us working on this (second) floor. That's ideal because there is high demand for staff attention and people summon assistance very frequently using call alarms. There are three of us working on the floor today, which means things take longer to do. It is hard when staff ring in sick; it makes us short staffed." Another staff member said, "Sometimes there is not enough staff if staff call in sick and we can't get cover."

We observed staff were busy on the second floor and many people were not supported from their rooms to communal areas until after 11.00am. Three people were left unsupervised in a communal lounge for 25 minutes before staff appeared to check they were okay. Staff told us this was because they were short staffed. We discussed these concerns with the registered manager. They told us they had already begun to take action to address these concerns, which they had been unable to address through the provision of agency or existing casual staff. Action included recent and on-going recruitment to permanent and casual staff vacancies. This would help to ensure sufficient contingency resources were available to respond to unplanned staff absence. When we asked the registered manager how they assured themselves staff were deployed in sufficient numbers to meet people needs, they told us they had 'inherited' sufficient staff when they started working at the service and hadn't changed or reviewed staffing levels. Following our inspection, they told us they would implement a dependency tool to enable them to demonstrate they used a systematic approach to ensuring sufficient staff were available to meet people's current needs.

Staff recruitment files required further development to ensure records reflected robust checks had been undertaken. The registered manager undertook pre-employment checks which included previous employment history, references and a check with the Disclosure and Barring Service [DBS]. The DBS provides information about a potential applicants suitability to work in the care and support services; supporting the employer to make safer recruitment decisions. We found recruitment files did not include any records to demonstrate the person's identify and proof of eligibility to work in the united kingdom. Recruitment records for nurses included a copy of their registration with the Nursing and Midwifery Council (NMC) but did not include details of their PIN, a number which is provided by the NMC to enable nurses to practice following their registration. This was held separately with interview notes. The registered manager told us they destroyed all personal information following the DBS check, but told us they would ensure future records clearly demonstrated these documents had been checked and verified. They told us they would keep details of nurses PIN numbers with recruitment files.

There were procedures in place for staff to report and record accidents and incidents in the service. We found records were fragmented, with information recorded in more than one format. This meant inconsistencies when reviewing the information. For example, one person's record referred to them

sustaining an injury following an accident. The record did not include what actions had been taken in response to the accident. We found this information had been recorded on a separate form, some days after the original accident. Records had not always been completed in a timely manner, with the date of the incident being sometime after the actual incident had occurred. The registered manager was working in partnership with the local authority and had implemented a new system of reporting, monitoring and analysing incidents. Revised records were more detailed and provided the information needed to enable staff to identify trends and patterns, and take appropriate action to reduce the risk of further incidents and accidents occurring.

Requires Improvement

Is the service effective?

Our findings

People's care was not always effective because records did not support effective monitoring and assessment of people's health needs. We found recording systems were fragmented and were not always sufficiently detailed to provide the information staff needed to ensure they were meeting people's needs. People's care plans, daily monitoring charts and daily handover notes were all held in three separate locations. Records were not filed, but bundled together collectively. As a result, care plans and records were not consistently updated or cross-referenced to reflect people's current needs. For example, one person's daily handover records identified a specific concern about their skin tissue. However, in the person's daily monitoring charts, it was clear that an additional health need was being monitored. Their care plan had not been updated to reflect this additional health need.

When we sampled monitoring charts, it was clear that some monitoring checks that were required in people's care plans had not been undertaken. There were gaps in records with no explanation to account for missed entries. One person had not received routine monthly monitoring of their clinical health needs for two consecutive months. These had then resumed with no reference to assessment of needs or reasons for the lapse in monitoring. Staff advised that records were 'bundled together' as senior staff reviewed and analysed them each month, before filing them with people's care plans. However, records were dated over several months which demonstrated they had not been reviewed in line with the provider's procedures. This made it difficult to identify if staff were undertaking effective monitoring and reviewing of people's health needs to support their health and well being.

Three people who we met were walking around wearing socks. Staff told us this was their preference. We noted two people had very long toe-nails which had ripped holes in the socks they had on. Staff told us this was because they regularly declined chiropody treatment. However, this was not clear in their care plans and staff had not assessed alternative strategies that could be explored to support people to maintain healthy feet.

Records were not effective in monitoring people's food and fluid intake where required. People were assessed for the risk of malnutrition and when required, specialist advice and support was sought. Records showed staff were recording fluids offered rather than quantities actually consumed. There was no daily target for people in terms of food and fluid intake. This information was detailed in people's care plans but had not been transferred to daily monitoring records. This is important to ensure people are receiving sufficient food and fluids in line with their assessed needs. A relative told us they regularly supported their family member because staff were not recording food intake correctly, and were recording that the person had eaten more than they actually had. They told us accurate recording was essential as their family member was at risk of weight loss and continued to lose weight. The registered manager told us they would review recordings with staff.

The registered manager told us they planned to merge all the care plans, daily handover records and monitoring charts into one care file for each person. This would help to ensure that an overview of each person's health care needs could be identified, monitored and addressed.

Staff told us they had completed training that gave them the skills and knowledge they needed in their roles. One staff member told us, "We have lots of training here each month; much of it is on-line. I have recently competed dementia awareness which has helped in how I support people living with dementia." Another staff member described how they were supported to undertake further vocational training to enable them to develop in their role. Nursing staff told us they had access to regular training on a variety of topics which helped to keep them up to date with best practice. They told us they could request specific training if they thought it would be beneficial for people they supported and this was encouraged by the registered and deputy manager.

We reviewed the provider's training matrix, which is a central record of staff training. This was not up to date and showed many gaps and anomalies in staff training. The registered manager provided us with an updated copy following our inspection. This showed staff had completed a range of training, as part of their induction into the service and on-going development. Staff were provided with regular opportunities to refresh their knowledge and experience. The registered manager was continuing to update the matrix as training was completed.

Staff told us they felt supported in their roles and received regular supervision which helped their development. One staff member told us, "I have supervision each month, the managers are really supportive." Another staff member said, "We receive good support from managers. [Name of registered manager] is very approachable".

People and relatives were positive about the meals provided. Comments included, "I enjoy my food most of the time. We get a choice and we have lots to drink during the day. They [staff] always check on us for fluids," "I get enough to eat here. If you don't like something, you just tell them and they will find you something else," and "Food is very good and they help me to eat out here (in the garden) if I can." One relative told us, "[Name] appetite has definitely improved since [name] came here. I explained to staff that [name] has had eating problems most of their life; staff listened, encourage [name] and weigh [name] regularly. This has meant [name's] weight has stabilised and looks better for it."

We saw people were provided with regular drinks and snacks throughout the day. The service employed a 'nutritional assistant' who was responsible for ensuring people had sufficient food and fluids throughout the day. When we spoke with them, they were unable to tell us about the specific nutritional needs of any of the people using the service. They told us they regularly went round with the tea trolley and supported every person to have something to drink and a snack to eat; though they did not monitor if these had been consumed.

We observed the lunchtime meal and saw people had been supported to choose their meal by staff. People were able to choose where they wanted to eat their meal, with some preferring to remain in their rooms or eat outdoors. Staff supported people's independence by providing plate guards and adapted cutlery. Where people required support to eat their meals, this was provided sensitively; with staff seated next to people providing encouragement and reassurance. People were given time to eat their meals in a relaxed atmosphere.

Records showed people were weighed regularly and referrals made where people had experienced weight loss that put them at risk of malnutrition. One visiting health professional told us staff made referrals in a timely manner where they had concerns about people nutritional needs; although staff were not always consistent in the view and information they provided about changes in people's needs.

Guidance about people's specific health needs was detailed and provided the information staff needed. One

person required nutrition through a PEG feed (a feeding tube inserted directly to the stomach). There was a comprehensive protocol and guidance for staff to follow on the safe management and positioning of this. A second person required support to manage their catheter care. Their care plan included clear instructions on the care and monitoring of the catheter site. Records showed staff were following NICE (National Institute for Clinical Excellence) guidance to ensure best practice and had included specific guidance from health professionals in people's care plans.

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 this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records showed people's mental capacity to understand and consent to their care had been assessed. When people lacked mental capacity, best interest decisions had been made, although records did not clearly demonstrate the process for making these decisions. Where possible, people had consented to their care. Staff demonstrated a good understanding of the principles of the MCA. We saw they sought consent before providing care or support and respected people's right to decline their care and treatment. The registered manager was able to describe the process they would follow if they thought someone was no longer able to make their own decisions and this was in line with guidance from the MCA. Some people were subject to DoLS authorisations, for example because they were unable to leave the service unsupervised or required constant supervision. These were kept under review and any conditions complied with. The registered manager kept a tracker which enabled them to monitor expiry dates of authorisation and ensure requests for review were made in a timely manner.

We saw people were able to move around the service but there was little signage to support people to orientate around the premises. Signage was in place on doors for toilets, bathrooms and lounges, but there were no directional signage to guide people to access key areas. We observed several people were drawn to the reception area, with some becoming distressed on occasions. There was little in the form of items of interest, interaction or stimulation for people in these areas, or indeed in any communal areas, which would help to occupy people and give them a sense of purpose.

The provider had undertaken decorating work in some areas of the premises and we were told this was on-going. We noted curtains in many communal areas were poorly fitted and little thought had been given to the layout and design of lounges to ensure they were homely, welcoming and comfortable. One communal lounge was empty pending redecoration and had been used to store discarded items. The registered manager told us they were in the process of creating a reminiscence room and was purchasing furniture and fittings to re-create a living room of by-gone eras. However, there was no target date for completion and as such some communal rooms remained empty. This meant other communal areas were congested at busy times during the day.

Each persons' room was numbered, and some had a photograph relating to the person. However, most rooms did not have anything to support the person to identify the room as belonging to them. References were made to the development of memory boxes, but these were not in place at the time of our inspection. People had not been involved or consulted about the decoration of the premises. For example, the interior of the lift had recently been refurbished and was decorated with a striking mural. When we asked the deputy manager about the decision making process to ensure the mural was suitable for people using the service,

they told us the registered manager had decided on it because they liked the theme.

Requires Improvement

Is the service caring?

Our findings

On the day of our inspection, we found some staff were rushed and did not always have the time they needed to spend with people, or provide care in a timely manner. One relative told us, "There are times when [name] is in a bed a long time during the day. I visit at different times and some days it has been nearly lunch before [name] is up and dressed. Then [name] can be back in bed by 6pm sometimes." We observed some people were not supported to get up until late morning, and three people were left without staff interactions for over 25 minutes. Staff told us they usually had time to care but were short staffed on occasions due to unplanned staff absence. The registered manager told us they were in the process of recruiting new permanent and casual staff to ensure there was always sufficient staff available to provide the care people needed in a timely manner.

People and relatives were otherwise positive about the care staff provided. Comments included, "The staff are really nice here. They are friendly and go out of their way to help you if they can," "The staff couldn't be nicer here. They know what I like and don't like," "The staff couldn't be kinder to me. They know what I need before I do sometimes. They are very patient with me," and "Staff are very caring and often stop to chat and find out how things are."

Visitors were welcome at any time. People told us their relatives were able to visit when they wished and relatives told us they were always greeted and welcomed by staff. People were supported to spend time with their families inside and away from the service.

Staff were knowledgeable about people's needs and interests. We observed staff communicating effectively with people, using different ways of enhancing communication. For instance, by touch, ensuring they were at eye level with people who were seated and altering the tone of their voices appropriately. Where people became distressed or anxious, staff promptly responded by providing reassurance and distraction wherever possible. For instance, where one person was distressed due to an unforeseen change in their routines, staff took turns to spend time with the person and ensure they had objects available that provided them with comfort and reassurance. Staff spoke with people to check on their wellbeing; asked if they needed help with a task or if they were comfortable.

People told us they were involved in discussions about their care, though this was not evident in care planning records. One person told us they were active in determining how they liked to be supported and cared for and said staff provided care as planned. Another person told us, "I don't remember them talking to me about my care planning but I know it all gets written down and I am happy to leave it to them. I trust them [staff]". Care plans were held securely and only accessed by appropriate staff. Staff completed documentation in private and were aware of the need to maintain confidentiality when discussing people's care or information; for instance, closing doors when handing over information.

People were supported to maintain their independence wherever possible. People's care plans included details of their abilities and areas where they were independent or required a minimum level of staff support. We saw staff encouraged people to do things for themselves before providing assistance, such as

eating and moving around the service.

Staff knew how to provide care in a dignified way and closed doors and curtains to maintain people's privacy. We observed staff knocked on doors and identified themselves before entering people's rooms. Staff addressed people in a respectful way, using their preferred term of address and taking time to listen to people. Staff were discreet in providing assistance to people who required support with personal care.

Requires Improvement

Is the service responsive?

Our findings

Care plans were reviewed regularly but did not evidence that people or their relatives had been involved in reviews about their care. People and relatives told us they had not been involved in formal reviews of their care plan. Some relatives told us staff regularly involved them and kept them up to date with changes to their family member's care. We found reviews of care records did not demonstrate a formal analysis of current care needs and if interventions were effective in meeting people's needs. Reviews did not always detail changes in people's needs. For example, one person had recently experienced difficulties in swallowing and staff had made an appropriate referral to external agencies for assessment and support. The person's recent care review simply stated 'no change to care plan' and made no reference to these concerns. Other entries in care reviews simply stated 'continue with care plan'. The registered manager told us they were in the process of completing updating of people's care plans and would ensure care reviews clearly reflected an analysis of people's current needs.

People's physical, mental health and social needs were assessed prior to them using the service. Care plans were personalised and detailed people's preferences and details of their lives prior to moving to the service in a document titled 'All about me'. This provided details of people's childhoods, family, working life and significant events; including support needed to enable the person to maintain spiritual and cultural needs and relationships. For example, one person communicated in their first language and had a limited grasp of the English language. There was one staff member who was conversant in this language. The care plan advised staff that the directors of the service were also conversant in the language and staff confirmed they often called upon them to spend time with the person, to ensure they were happy with their care and had everything they needed. This information supported staff to provide person centred care.

Records showed staff were responsive to changes in people needs. For example, staff made referrals to dieticians or to mental health agencies if they were concerned about changes in a person wellbeing. Staff we spoke with discussed people in a person centred way and demonstrated that they knew people's individual routines, likes and dislikes. One staff member told us, "Some people can't tell you what is wrong but you can tell by little changes in their behaviours or responses that something isn't right."

People shared mixed views about the range of activities available in the service. Comments included, "I have been asked what I want to do but usually I end up knitting with [friend]. There are entertainers who come in, like a singer or the children at Christmas, but on the whole there is not much going on here," and "The activity co-ordinator worked with [name] and got [name] knitting, painting and drawing again, but unfortunately they left recently. The new activity co-ordinator is lovely and very keen but seems cautious around people." We observed some people engaged with activities, such as knitting, sorting objects or spending time in the garden, but most people were not engaged in any meaningful activities during our visit.

The activity co-ordinator was new in the role and told us they were building relationships with people and staff. They were able to discuss plans to improve activities and stimulation for people, which included tactile sensory walls, colours, visiting animals and gardening. Current activities included group games and one-to-

one activities in people's rooms; such as painting, colouring and picture boards. We observed the staff member was cautious in their approach with people and they told us they were worried about doing the wrong thing with people. We discussed these concerns with the registered manager who told us they would ensure the activity co-ordinator had the support, resources and encouragement they needed to be effective in their role.

Where people had sensory losses, such as poor hearing or eyesight, or cognitive impairment, care plans guided staff on how they should communicate and share information with the person. For example, staff supported one person to use eye and cue cards to enable them to communicate and make decisions and choices. This helped to ensure people were provided with information in a format they could understand. The provider had yet to develop a policy to demonstrate how they complied with their responsibilities under the Accessible Information Standard (AIS). This AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given.

People and relatives told us they were confident to raise concerns and complaints. One person and two relatives told us they had raised concerns about the laundry service, with items getting lost or mislaid. They told us they had not escalated their concerns into formal complaints but, so far, there had been little improvement in response to their concerns. The provider had a policy in place which detailed how people's complaints would be managed. This required review to ensure people were provided with contact details of the local authority as an external authority to which they could raise their complaint. We saw the provider kept a log of complaints but the registered manager was unable to locate any records pertaining to complaints received in 2017. Therefore the provider was not able to evidence complaints over a 12 month period prior to our inspection.

Complaints received in 2018 were mainly related to care issues. Records were detailed and showed complaints had been investigated and complainants provided with a clear response. This included actions the provider intended to take to reduce the risk of further complaints. Where people were not happy with the response of the provider, they were able to escalate this to appropriate external agencies.

Advanced decision care planning was in place but this had not always been fully completed. This presented a risk that people's choices and preferences for their end of life care may not be available for staff when the time came. The registered manager told us they would ensure this documentation was completed wherever possible. Staff had completed appropriate training and the provider had policies in place to support people who were in need of end of life care.

Requires Improvement

Is the service well-led?

Our findings

The registered manager provided us with evidence of a range of audits and checks which helped them to monitor the quality of the service. They told us they spent time with staff explaining audits and checks and then key audits were dispersed to staff to undertake. These included audits of care plans and care records. The deputy manager was responsible for undertaking audits and checks on the environment, the kitchen, health and safety and clinical issues. The registered manager provided us with detailed action plans from December 2017 to June 2018, referred to as 'RAG' which were used to identify where improvements were needed. These documents reviewed progress of improvements and identified timescales for the completion of remedial action.

We found audits and checks were not effective in driving sustainable improvements in the service. For example, action plans completed in June 2018 by the registered manager identified an 'improving picture' with many action plans noted as being completed. These included the review and update of care plans and records and staff training. We found audits and checks were not effective in monitoring and evaluating the quality of care. Some shortfalls identified during this inspection had not been identified. Concerns included poor management of infection control had not been identified through the provider's audits.

The provider had an infection control policy which had recently been reviewed. The policy did not include details of how risks were managed in respect of cross contamination of clean and dirty laundry. There was a reference to the required dress code for staff; this did not make any reference to jewellery and potential risks in staff wearing these which is standard practice. There was no guidance on cleaning schedules or deep cleaning within the service. People's care plans and records did not always include the information and guidance staff needed, and were not updated in a timely manner to reflect current needs. Medicines were not always managed safely. The provider did not have robust contingency procedures to ensure sufficient numbers of staff were always deployed to meet people's needs. Staff training records were not up to date or accurate. People's health needs were not effectively monitored to protect them from the risk of infection or risk associated with their health conditions.

This failure to operate effective systems and processes to monitor and assess the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements were evident as a result of action planning. For example, the review and update of people's personal evacuation plans [PEEPS] and the implementation of a traffic light 'dot' system above doors to people's rooms. This provided guidance for staff on the level of support each person required in the event of an emergency evacuation. We saw this action had been completed.

People and their relatives provided mixed views on the leadership and management of the service. Comments included, "The [registered] manager and staff are very helpful," "I have been asked for feedback about the service, which I feel is very positive. I leave here with peace of mind knowing [name] is being looked after," "The management are not very good at keeping us informed of what is happening to [name]. I don't think managers are approachable, although staff work vey well together and support each other," and

"This is the third or fourth manager in the five years we have been here which I think is part of the problem."

There was a registered manager in post who was supported by a deputy manager. Staff were supported in day to day duties by a senior care worker who managed the shift and reported to nurses in charge. Staff were mostly positive about the leadership of the service. They told us they felt supported by the registered manager, who they described as "Approachable". Two staff members felt communication needed to improve between managers and staff and action taken to resolve concerns, such as response to unplanned staff absence.

Staff were able to share their views in staff meetings, although these were not held regularly. We looked at the minutes of a meeting held in February 2018 and saw these was used to discuss key policies and best practice in safeguarding and whistleblowing. Roles and responsibilities were reviewed and discussed, including a clear expectation that staff would complete required training. Staff surveys had been completed in February 2018. Staff were positive about their work but felt improvements were needed to staffing levels, frequency of supervisions and communication about people's needs. These remained concerns at the time of our inspection.

Staff spoke about positive teamwork and supporting each other; including respect for each other's diversity. Staff gave examples of how they were supported to pursue their religious beliefs which included recognising key festivals and celebrations across a range of different cultures and supporting each other to have planned leave during these times. Staff told us they enjoyed their work and spoke of feeling 'like a family' whilst a work. Staff demonstrated they shared the provider values of providing personalised care to people using the service.

There were limited opportunities for people to share their views. We looked at satisfaction surveys completed in February 2018. Responses were mostly positive, with suggestions for improvements to the laundry service and the environment. Records did not demonstrate the provider had made sustainable improvements as a result of this feedback.

The registered manager had not undertaken any meetings to enable people or relatives to share their views face-to-face. They told us this was because most people were not able to share their views in this type of forum. We recommended they researched and explored alternative methods of gaining people's views based on current best practice; particularly for people who were living with dementia.

The registered provider and the registered manager were aware of their legal responsibilities, including notification of significant events and incidents within the service. They had displayed their current ratings clearly at the service. This is important to enable people using or looking for care services, to make informed choices about their care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the prevention and control of infection. The provider did not have robust systems that ensured the premises were consistently maintained and risks effectively assessed. Risks to the health, safety and wellbeing of people were not always effectively assessed or monitored. Records did not provide sufficient detail or guidance to identify measures needed to reduce the risk of harm. Medicines were not always stored or managed safely.

The enforcement action we took:

Notice of proposal to impose positive conditions to restrict any new admissions to the service.

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 did not operate effective systems and processes to make sure they assessed and monitored the quality of the service.

The enforcement action we took:

The provider is required to submit monthly action plans outlining the progress and completion of required improvements.