Ashbourne House Care Homes Limited

Ashbourne House - Bristol

Inspection report

2 Henleaze Road, Henleaze, Bristol, BS9 4EX.
Tel: 0117 962 8081
Website:

Date of inspection visit: 20 and 21 August 2015
Date of publication: 29/12/2015

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 this inspection on 20 and 21 August 2015 and it was unannounced. When Ashbourne House was last inspected in November 2013 there were no breaches of the legal requirements identified.

Ashbourne House is a 17 bed residential home for older people that provides accommodation for persons who require nursing or personal care. At the time of our inspection there were 12 people living at the service.

The overall rating for this service is 'Inadequate' and therefore the service is 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

Summary of findings

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.

There was a registered manager in place at the time of our inspection; 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.

On the day of inspection the registered manager was on annual leave. The home was represented by a senior member of staff.

The home was not suitably safe and clean. The hygiene practices of staff did not meet the Department of Health guidance for the prevention and detection of infection.

The administration of medicines was not in line with best practice.

The provider had not made appropriate arrangements to identify and respond to allegations of abuse. Staff were not aware of the provider's safeguarding policy and how to respond to actual or suspected abuse to keep people safe. The provider had also failed to act appropriately in reporting potential abuse to the local authority safeguarding team.

The provider did not operate safe and effective recruitment procedures to ensure only suitable staff were employed at the service.

There were not sufficient numbers of staff to support people safely.

We saw that appropriate action was not taken in response to unsafe incidents, including steps to reduce the risk of them reoccurring.

Staff did not have a good understanding of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS). The registered manager had not made applications for DoLS where they had been required. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Staff appraisals and supervisions were not undertaken as planned and the registered managerfailed to monitor and feedback on staff performance.

The provider did not have a system to monitor records made by staff or records that related to the management of the service.

The provider failed to ensure that people sustained good health by the means of providing nutritious food and sufficient drinks to people.

We observed occasions where people's care and dignity were compromised. People were not given choices in their daily routines.

People were not supported in promoting their independence through activities and community involvement.

Care was not consistently person centred. Care plans were not personalised and did not contain unique individual information and references to people's daily lives.

Risk assessments did not always reflect actions required to reduce risks to people.

Statutory notifications had not been made to the Commission for notifiable incidents.

Summary of findings

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

Staff felt that their views and concerns would be listened to but were not confident these would be acted upon.

We found ten breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report

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.

The home was not suitably clean and people were at risk from poor hygiene practices.

The disposal and administration of people's medicines were not in line with best practice.

There were not enough staff to meet people's needs promptly.

Staff were trained in safeguarding adults. However, they did not understand their responsibilities to protect people from potential abuse.

The provider's recruitment procedures were not effective in ensuring only suitable staff were employed at the home.

Is the service effective?

Inadequate 

The service was not effective.

DoLS applications had not been made for those people that required them.

Staff did not demonstrate good knowledge of the legislation or the Mental Capacity Act 2005.

Records relating to people's care and treatment were not fully completed to protect people from the risks of unsafe care.

Staff supervision and training was not up to date.

The provider failed to provide people with nutritious food and sufficient drinks.

Is the service caring?

Requires Improvement 

The service was not always caring.

We observed occasions where people's care and dignity were compromised.

People were not given choices in their daily routines.

Is the service responsive?

Inadequate 

The service was not responsive.

Care was not consistently person centred.

Sufficient action had not been taken to ensure people's care records were fully completed.

People were not supported in promoting their independence through activities and community involvement.

Summary of findings

Care plans were not personalised and did not contain unique individual information and references to people's daily lives.

Risk assessments did not always reflect actions required to reduce risks to people.

People were supported to use healthcare services.

There were systems in place to respond to complaints .

Is the service well-led?

Inadequate

The service was not well led.

Statutory notifications had not been made to the Commission for notifiableincidents.

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

Staff felt that their views and concerns would be listened to but were not confident they would be acted upon.

Ashbourne House - Bristol

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.

The inspection took place on 20 and 21 August 2015 and was unannounced. This inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we had received in relation to the home; which included any incident notifications they had sent us.

During the inspection we spoke with seven people who lived at the home and who were able to share their experiences and views with us. We spoke with two people's relatives who visited the home whilst we were there. We also spoke with five staff members. This included the activities staff. We observed how people were supported and looked at five people's care records. We also made observations of the care that people received.

We looked at records relating to the management of the home such as the staffing rota, policies, incident and accident records, recruitment and training records and audit reports.

Inadequate

Is the service safe?

Our findings

The premises were not secure and did not ensure that people were kept safe from intruders. We arrived at the home to find extensive building works going on outside necessitating the use of a different entrance to gain access. As we approached the entrance we saw two members of staff, the staff did not ask to see our identification or ask who we were. The entrance was open and when no one answered the bell we walked in.

The inspector walked into the hallway area and then into the kitchen where there were three staff. The inspector shouted 'Hello' several times this did not distract the staff talking in the kitchen. The inspector continued into the hallway of the home and up the stairs to seek out the registered manager. The inspector continued to walk around the home on all three levels and spoke with people living there unchallenged by any staff.

The inspector found that there were no other staff in the home other than in the kitchen and outside. The inspector returned to the kitchen whereupon they had to shout 'Hello' several times and knock on a kitchen worktop in order to gain the attention of the staff. The staff then questioned who the inspector was but did not ask to see any identification. The lack of security and attention paid by staff to the inspector entering the premises meant that the premises were not kept securely and the provider did not ensure people were kept safe from intruders.

The kitchen was not suitably clean. The work that was going on outside and in the basement of the home meant that the entire kitchen was covered in a film of dust from the works and the floor was dusty and dirty. We observed a lack of hygiene in the kitchen and no clear designation to separate workmen from the home.

Due to the ongoing works we found that freezers that had been stored in the basement of the home had been moved to an outside lock-up in the garden. We saw that the freezers were kept in an unhygienic area . We looked in the freezers and found that food storage was unhygienic and put people at risk of eating contaminated food.

Outside of the lock-up we saw that bin bags full of domestic rubbish were torn and rubbish was scattered across the garden. This rubbish was removed after the inspector pointed it out. We also saw that old mattresses and fencing were left outside on the lawn area and that disused mobility equipment had been left by the garden door. The garden was a hygiene hazard and unsafe for people to access.

These failings amounted to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

The Department of Health (DH) publishes the Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance ("the Code"). The Code sets out the basic steps that are required to ensure the essential criteria for compliance with the cleanliness and infection control requirements under the Health and Social Care Act 2008 and its associated regulations are being met.

The provider had not followed the DH code of practice on the prevention and control of infections. People were not cared for in a clean and hygienic environment.

There was not a dirty to clean flow for laundry In the laundry room. We found it cluttered with furniture such as fold up beds and other items such as paint tins, rollers and roller trays, cleaning materials, clean clothes hung up in the doorway and dirty mops. The work surfaces were dirty, as was the sink which had lime scale, dried up tissues, a dirty bar of soap, rusty cans and leaves left on and around it. There was also damp plaster and paint coming away from the wall. The work surfaces were cluttered and not seamless. There was also open shelving in the room which had gloves and aprons on it. There were dirty damp mops left head down on the floor which meant that bacteria could develop. The laundry area increased the risk of cross contamination and the spread of airborne infections.

We also observed a member of staff who was cleaning stop to help with serving meals without changing their gloves and apron. This increased the risk of cross contamination.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

A Disclosure and Barring Service (DBS) check had been completed for all staff; DBS checks ensure that people barred from working with certain groups such as vulnerable adults and children would be identified. This meant that

the provider had ensured that staff did not fall within this group of people. Although DBS checks had been completed there were not effective recruitment and selection procedures in place.

The provider had not ensured that staff were of good character and suitably competent for the positions applied. There were not effective recruitment and selection processes in place as new staff were not subject to suitable recruitment procedures. Not all of the required pre-employment checks had been completed and recorded. The records showed that not all recently recruited staff had previous experience of working in care. We looked at three staff files; we found that one person did not have an application form and that the other two were incomplete. This meant that gaps in employment could not be demonstrated as checked and addressed. There were also no records of interviews to demonstrate how candidate competency and suitability had been assessed and full references had not been obtained.

These failings amounted to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

People in the home were not protected because staff did not know the processes to follow if they were concerned about poor practice or the safety and welfare of people living in the home.

Staff had received training in safeguarding adults and the prevention of abuse. However when the staff on duty were asked, they were unclear on how to raise safeguarding concerns and which organisations they could contact to raise concerns about the welfare of people in the home. A safeguarding incident also occurred whilst the inspector was present, this was an incident which required a referral to the local authority safeguarding team although the staff did not know how to do this and asked the inspector to assist.

Whilst looking at accident and incident records we found that the registered manager had not referred incidents which met the safeguarding criteria to the local authority safeguarding team or notified the Commission of possible abuse. We saw examples of this in relation to incidents which involved emotional, mental and financial abuse. The registered manager had failed to respond appropriately and according to their own safeguarding procedures.

These failings amounted to a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

There were not sufficient numbers of staff to support people safely. On the day of the inspection there were three staff on duty; one member of staff was allocated to cook the meals and two further staff, one of whom was undertaking the cleaning for the day. There were no auxiliary staff; the care staff were rostered to cook and clean whilst undertaking their care role.

The home was on three levels which meant that most of the accommodation was not covered by any staff presence when they were busy with cooking and cleaning duties leaving just one member of staff to provide care to people. Whilst meals were being served we observed that all three staff were busy plating, and serving meals in the kitchen and dining room areas on the ground floor of the home. There was no other staff available to assist people in other areas of the home where people were residing. The level of staffing within the home meant that there was a risk of people's needs not being met. We heard a member of staff saying to a person who was up walking round '[name of person] can you go back in the lounge and sit down please,' because the staff member was too busy to give the person their attention, we saw this happen a few times during our inspection.

We observed that staff were task orientated to complete what needed to be done and did not stop to spend much quality time with people. All of the care staff we spoke with described their roles in relation to tasks and told us they had little time to spend with people, they also described every morning as being particularly hectic. Staff also referred to a time in the past when the staffing included a cook and a cleaner and how that level of staffing had enabled them to spend quality time providing people with care that met their needs. A relative we spoke with said that they definitely felt their relative was safe but there were not enough staff and some of them came across as not having the right skill base. People told us that staff were always too busy to spend time with them.

We looked at the rosters and found that there were two staff rostered as 'sleeping nights'. We asked what this entailed and were told that two members of staff slept on fold out beds in the communal lounge on the ground floor from 10pm onwards. This meant that there were no staff covering all areas of the home during the night. The

Inadequate

Is the service safe?

expectation was that the staff would awake on hearing a noise or call bell. However should a person have had an incident or a continence issue on the other floors of the home and could not reach their call bell or call out loudly it was unlikely the staff would be woken to meet their needs. There were no risk assessments in place for the level of night staffing or a dependency assessment to ensure there were sufficient staff to meet people's needs at other times.

These failings amounted to a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we also looked at the arrangements for the storage, adminstration and disposal of medicines. We found that unused medicines were not disposed of securely. The container, in which unused medicines were placed was an open basket with no records kept of waste medicines consigned for destruction. Staff were unable to give us assurance that medicines were safely disposed of and were not aware of any receipts for returned drugs.

Some people had been prescribed medicines, such as pain relief, which were to be given 'when required' (Controlled Drugs). We found whilst checking the administration and stock records that the stock levels had been incorrectly recorded and that medicine carried forward was not shown on the administration records and therefore the actual number of medicines did not correspond with the records. Furthermore during medication audits this had not been picked up by the registered manager.

At the time of our inspection, people's medicines were available for them. However a relative did tell us that one of the people living in the home regularly ran out of their medicine. They said they would have to wait until the next delivery before it was available again. Staff told us they did have some problems with delays in the supply of medicines but that this had improved .

The pharmacy provided printed medicines administration records for staff to complete when they had given people their medicines. We looked at the records in each area of the home. These had been completed appropriately and showed people had been given their medicines as prescribed. Additional information was available for staff to help ensure that people were given these medicines correctly. People confirmed their medicines were given regularly at set times by the staff on duty although one person did comment that when medicines were given before their meals "the taste of the medications spoils the taste of my meal".

People told us that they felt safe and cared for by staff and that the home had a homely atmosphere. Many of the people said they did not use their call bells very often as they were quite independent. We received mixed comments about whether staff came straight away. One person said "I don't have to wait too long for the call bell to be answered".

Inadequate

Is the service effective?

Our findings

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS): Code of Practice and the Mental Capacity Act 2005 Code of Practice. Providers must at all times act at all times in accordance with this Codes. DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. We found that no DoLS authorisations had been sought by the registered manager. We found however that there was one person using the service who required an authorisation in place. We observed a number of occasions when the person who did not have full mental capacity was prevented from leaving the home by distraction, blocking and by staff leading the person away from the open back door where other people were able to come and go freely. On one occasion we observed the person being 'caught' walking out of the open back door by a member of staff who guided them back into the home. As they did this the person said 'I can go up and down stairs all day by myself and yet you won't let me go outside?' The provider had a DoLS policy in place but this had not been followed. This meant there was a risk that people were being deprived of their liberty without sufficient measures in place to protect them from harm. Following the inspection the inspector made contact with the local authority DoLS team in relation to what we had found.

Staff we spoke with had undertaken DoLS and MCA training but did not demonstrate a good knowledge of the legislation in relation to people living in the home.

These failings amounted to a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently supported through an effective training and supervision programme. Staff had completed a variety of training courses relevant to their role, such as manual handling, food hygiene, infection control and safeguarding adults. Training records did not demonstrate that staff had received appropriate induction training. We were told by the staff that they had learned 'on the job'. We also noted delays in ensuring that regular refresher training had been undertaken as required by the provider. Further to this, training records were not up to date; this meant that it was difficult to ascertain which staff required training. The provider had failed to provide staff with training to enable them to carry out the duties they were employed to perform.

Staff said they had received performance supervision however when we checked records we found that this had been irregular; the supervision records we looked at supported this. Supervision was expected quarterly, when we checked four staff records we found that staff A had received regular supervisions. Staff B however had not received any supervisions since October 2014 and staff C had not received any since May 2014. Staff D had received one supervision in 11 months. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. Further to this, the supervisions that had been undertaken were lacking in any detail, there was no detailed feedback about performance, discussion of training and development needs. Staff comments from some of these supervisions were the same one sentence which had been copied from one supervision to the next. The provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

These failings amounted to a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to ensure that people sustained good health by the means of providing suitable, nutritious food and hydration.

People did not receive a varied diet. There was no allocated chef or menu to view. Staff cooked for people as part of their daily duties. We looked at what people had eaten for the previous three weeks and it was clear that there was an excessive amount of bread in the daily menu. We were told by senior staff that it was a case of whoever was cooking looked at the previous two or three day's meals and chose something else from what was available in the freezer. We found that there was no assessment of the diet being nutritious or involvement of a dietician so people could be assured that their diet was suitably nutritious. There was no cooked breakfast offered at all; people had a choice of toast or cereal. At lunchtime people received a cooked meal including some fruit or vegetables. We observed that after drinks were served in the morning a member of staff came round with the 'menu book' to write down what

Inadequate

Is the service effective?

people would like for their evening meal. The choice being a cold meal of 'paste sandwiches; beef, ham, salmon, chicken or crab, or they could have bread and spread with jam or marmalade. There was nothing else offered until one person who didn't want bread and spread was offered a fried egg on toast to which another person responded by saying 'that's what I'll have it's my favourite'. The menu did not meet the dietary recommendations of five a day fruit and vegetables. It was clear by looking at the daily records that most people had toast for breakfast and sandwiches or 'bread and spread' for their evening meal nearly every day for three weeks of records we looked at.

There was an inadequate supply of hot and cold drinks to people throughout the inspection. There were no cold drinks readily available in the lounges or communal areas and people were only offered hot drinks after breakfast once at mid-morning and again once in the afternoon and evening. If anybody wanted a drink outside of these times they would need to find a member of staff to make them a drink. We observed one person walking around the home looking for a staff member to make them a hot drink, this person told us that they had asked for a hot drink and a staff member had said they could have one together but that the staff member appeared to have become busy and forgotten.

These failings amounted to a breach of Regulation 14 (1) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People's dignity and respect were not always protected. We observed several examples of people's dignity being compromised. For example, on entering the home we saw one person with their underwear around their ankles in the hallway calling out for staff assistance. We asked the person if staff were attending and were told they had been waiting 20 minutes and so had come into the hallway to see if they could summon staff. The person was visibly distressed at having been seen in this position. The inspector went into the kitchen where the staff were congregated and had not yet realised the inspector was in the home. Having gained the attention of staff the inspector explained that a person who was partially dressed in the hallway required their assistance straight away. One of the staff replied "yes we know" and did not appear concerned. Another member of staff then asked "who are you?", on realising the inspector was from the Commission the staff immediately went to the assistance of the person. There appeared to be no hurry to assist the person until the staff realised an inspector was present. For this period of time, the person's dignity had been compromised. We also saw another person being told by staff "I've already told you" repeatedly when they asked the same questions. This person had dementia and the lack of attention paid to them visibly increased their confused and agitated state.

Observations and discussions with people suggested that people didn't always receive the care and attention they required. Where people had concerns about the quality of care provided, they felt this was due to low staffing levels rather than the abilities and approach of individual staff members. We found that people's care needs were not always met and that staff were slow or brusque to respond when people asked them for drinks or answering questions because they were already busy. We observed a person asking a member of staff when the chemist was coming, to be told by the member of staff 'I don't know, I'm normally upstairs aren't I?" There was no offer from the staff member to find out.

There were other occasions when staff appeared to be in a hurry or task orientated. When serving lunchtime meals people were told "here's your dinner/pudding [person's name] ", only two people were told what the dessert actually was. We also observed a person get up to leave but was told "you need to stay seated for your medication".

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Routines and systems in the home did not allow staff to be as caring as they would like to be. Staff told us they knew the importance of ensuring people had choice in their day to day lives but told us this was difficult to achieve given their numbers and what was available for them to cook and provide at mealtimes.

It was also apparent that not all staff knew people well or had taken account of their preferences. We observed a staff member serve hot drinks and biscuits during the morning. The staff member did not offer a choice, just made the drink and handed it to the person. The person asked for sugar for their drink, to which the staff member replied 'I have put sugar in but would you like some more.' The person replied 'Yes please'.

We also observed friendly interactions between staff and people which indicated a good relationship had developed between them. Throughout the day there was a warm and friendly atmosphere within the communal areas of the home. Some of the conversations observed were light hearted between staff and people.

Staff were mostly kind and caring in their approach. For example we observed a member of staff calm down a person who was agitated and upset, by suggesting they had a 'beauty treatment'. We observed this person become calm and settled whilst the member of staff painted their fingernails.

Most people living in the home were independently mobile. When people were not, staff were attentive in their approach when supporting people with their moving and handling needs. We observed one person being supported to stand from a seated position. The staff member gave the person calm clear instructions, talking to and reassuring them at each stage of the procedure.

Inadequate

Is the service responsive?

Our findings

The provider had failed to ensure that people received care and treatment which met their needs and preferences. The service was not consistently responsive to a person's needs.

We discussed person centred care with people and their relatives. Overall, people told us their views were respected, however they also gave examples of when this was not always the case. We also observed this. We discussed with people the choice of going to bed and getting up again. They told us, that as there was no choice in when breakfast was served; it was provided in their rooms from 7am even if they were asleep and that this would wake them up. We asked people about evenings and the choice they had going to bed. We were told that most people were encouraged to go to bed before the night staff came on duty at 10pm, as the staff slept in the 'residents lounge'. The staff confirmed that the night staff did sleep in the lounge but that if someone insisted on staying in the lounge past 10pm they would wait to sleep.

We also found there was a bath list for people that required assistance. This list gave set times once a week for people to receive a bath, other than for one person who had a daily 'wash' and another who was fully independent. There was no choice available to people to take a bath as and when they wished. We asked staff about this and were told they would try to accommodate people's requests for an additional bath outside of the list however it would depend on the number of staff available.

These instances did not demonstrate that care was consistently based on people's choice and had, on occasions, been done for the convenience of staff.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had some choice in food but that it could be improved. There was no set menu with a variety of choices for people to choose from. There was also no choice of a hot cooked breakfast, when we asked why this was we were told by staff that the night staff served people with breakfast in their rooms between 7am and 8am. This was because of the 'wake up' time of the night staff there was not enough time to cook and provide people with a cooked breakfast before the end of their shift. This was further exacerbated by the fact that morning medicines were also given by the night staff to one person at a time over the three floors of the home, with the staff member running up and down the stairs to and from the locked medicines cabinet as there was no lockable medicines trolley.

In relation to food one person said "I don't think I have ever been asked what I would like, but mostly we need a proper chef or cook not just take turns with who's available." Another comment was "I expect wages will be a problem, but tea time can be bad, but we do get milk and biscuits at 8pm. I'm disgusted with tea." We also observed that when the lunchtime meal was served one person said "I don't want sausage today" at which the staff member went to consult another staff member in the kitchen who confirmed that the person had ordered sausages, the person repeated "I don't want sausages today." There appeared to be reluctance from staff to alter the planned meal. Eventually the person was asked "Would you like a fried egg instead?" the person agreed and the staff member took the sausages away and replaced it with a fried egg, mash and peas. The person looked at the fried egg on the plate with mash and peas and said "Vinegar might give it a bit more flavour, but I don't know". The replacement of the sausages with a fried egg did not appear to be a palatable alternative but as the only alternative the person accepted it.

Other people said "The food is OK but sometimes it's a bit chewy, there's no proper cook so the items vary". Another person commented on the meal "My favourite hate, sausages, I only like good ones really and there is way too much gravy on this dinner, why can't they put it in a jug for us to pour like they used to?" The person left a sausage and three quarters of their mash saying "it wasn't nice and there was too much gravy". On leaving the meal there was no check by the staff that the person had enjoyed the meal or eaten enough.

These failings amounted to a breach of Regulation 14 (1) (4) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people's care plans identified activities that were suitable for the individual concerned; however recordings were not made on a regular basis in people's daily records to monitor the suitability and provision of activities for people. This meant it could not be monitored and confirmed if people's social needs were being met.

Inadequate

Is the service responsive?

People we spoke with also told us that they received very little one to one quality time with staff. One person said that the registered manager visited them in their room every few days as the person tended not to mix with other people and spent most of their time in their room watching TV. The person said it would be nice if staff had time to stop and chat even for a few minutes, but they were always too busy. A relative said "[name of person] always likes it when they clean her room as the cleaners always chat with her while they are doing it, it means she has 15 to 20 minutes of socialising and a good conversation which she loves."

People were not supported in promoting their independence and community involvement. People told us they were not routinely asked if they would like to go outside and that the provider did not provide access to the local community or to the outside areas of the home. We were told by people and staff that there were no trips outside of the home for people and that if people wanted to go out in the community then they relied on friends and relatives to take them if they were unable to take themselves. Staff we spoke with confirmed that the only time they went out with people was to assist them to a health appointment and that there were not enough staff to enable outings. A relative said "There are no outside visits unless families take them out and I haven't ever seen the garden being used though it's not safe at the moment. The building works have been going on for at least two and a half months now, when will they be finished? It would give a chance for the residents to at least be taken for a walk round the garden."

Activities were available for people but not on a daily basis. Activities were held weekly or bi-weekly and there were no activities at all on the weekends. Activities were not advertised in the home and therefore there was no plan to which people could organise their day. A relative told us "[name of person]enjoys the painting on Tuesdays, but extra staff would allow someone to interact socially with residents". During the inspection, two activities coordinators arrived saying they came every two weeks to do a morning activity and this had been booked up as a regular day. They started setting up and put some music on, but it was too loud to be able to hold a conversation even though one of the coordinators went round the room chatting with people. The coordinators organised various activities with the six people present in the lounge but didn't go around the home and let other people know they were there in case more people wished to attend.

The provider did not maintain accurate, complete and detailed records in respect of each person using the service. Care plans were not personalised and did not contain unique individual information and references to people's daily lives. There was no detailed information about people's daily preferences such as waking , sleeping times, their life history or information about their family relationships. This meant there was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for. This can be significant in an environment with people who have dementia as the information can aid staff in communicating with the person. This kind of information is of particular relevance when new staff are employed at the service to aid these staff in knowing and understanding people.

The home had completed an assessment of people's risks and had recorded guidance on how to manage identified risks. The risk assessments showed that assessments had been completed for areas such as nutrition and falls. Levels of risk had been updated at reviews when people's level of risk had noticeably changed. However, this was not always aligned to any action with regards to minimising or reducing the higher level of risk. We saw an example of this in relation to people whose weight had significantly decreased. The level of risk had been amended to reflect this yet there had been no recorded action to help minimise risk to the person or monitor them for the cause of the weight loss. This meant that opportunities to apply preventative measures were missed.

People's care plans were reviewed but did not always identify any changes in the level of support people may require. Care records showed that reviews were completed regularly. However we found that the reviews did not always lead to the required changes in people's care plans. We also found that daily records were not monitored to ensure that changes in people's behaviour and health were analysed to prevent issues from occurring. This was confirmed by one relative who said when speaking about a person; "Last time she had a fall they settled her, called us and the doctor, who arranged antibiotics as the fall was probably due to the UTI (urinary tract infection) she had. The home is reactive rather than proactive, if they noticed the changes like I did when she lived with me, they would know she is going down with a UTI and could do something before the fall".

Inadequate

Is the service responsive?

These failings amounted to a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did also comment that communication between staff was sometimes lacking and records of requests were not always passed on. A relative also commented "more staff would definitely help and communications between staff needs to improve, mum will talk to a carer but when the next carer comes on duty they are not aware mum has said anything".

People were supported to use healthcare services. People had regular health reviews with their GP and other healthcare professionals. When a person required additional regular clinical support this was provided. For example, one care plan showed that the person required regular wound dressing changes and we saw that a district nurse had been requested to assist with this. There was also evidence of input from the district nurse, community psychiatric team and GPs in people's records. We saw within everyone's care plan that regular visits or appointments with dentists, opticians and dentists had happened when required.

People and their relatives felt able to complain or raise issues within the home. The home had a complaints procedure available for people and their relatives. People and the relatives we spoke with told us when they had reason to complain the registered manager had dealt with the complaint well A relative said, "The manager knows her staff and that when my mum first came to the home I had to complain about one of the care assistants. The manager dealt with it very professionally and it was resolved well and now that care assistant is one of mums best friends with no grudge at all, it is more like a big family and that's what mum likes". Another person said that if they were concerned about something "I would go to the manager and she would listen to me and try to help".

People were able to maintain relationships with friends and family. Several people said that friends and family could visit at any time and relatives confirmed this.

Inadequate

Is the service well-led?

Our findings

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that in the absence of the registered manager, the staff did not know about the recording and informing processes for statutory notifications. Further to this we also found that the registered manager had not responded appropriately in making statutory notifications to the Commission in relation to serious injuries and allegations of abuse. We found that a number of incidents we looked at constituted statutory notifications and none had been made; the staff had been unaware that the incidents had required reporting to the Commission as statutory notifications.

These failings amounted to a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

There were systems in place within the home to monitor quality and safety, however these had not been fully effective in ensuring consistent and good quality care was delivered throughout the service. We saw records of quality audits completed by the registered manager which included areas monitored such as: health and safety, infection control, care plans and medicines. These audits were completed on a monthly, quarterly or annual basis according to the type of audit. Their systems had failed to identify and adequately action the shortfalls found at this inspection. This included concerns surrounding cleanliness, security, the accuracy of the person-centred information, the lack of detailed staff instructions to assist people with their care and welfare and inappropriate arrangements were in place to safely manage medicines. We also saw that three clocks around the home had stopped or were set to an incorrect time, we observed this as confusing for people living in the home. The staff appeared to know about this and explained that the registered manager was aware that the clock times were an issue for people, there was not however any record of this or action taken to resolve the issue.

The provider's quality assurance processes had not ensured that the premises and equipment used by the service were safe for their intended purpose and were used in a safe way. For example we observed a toilet seat riser which was loose and able to fall off, if not used carefully. These types of issues were not picked up during quality audits.

There was a governance system in operation to monitor medicines. We saw that when this system was used, staff recording errors were identified and this message was conveyed to staff. However, we found that the system had incorrectly recorded that medicine stock level records were correct. This meant that the system used was ineffective in identifying recording omissions like those that we identified during our inspection. We also saw that where audits had found issues to be rectified, action plans had not been completed and the next audit did not follow up the previous concerns.

The provider did not have an effective system to monitor the quality of people's care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them and there was a failure to identify care records with recording errors and omissions and to analyse concerns as highlighted in this report. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

The provider had failed to assess, monitor and improve the quality and safety of the service to people.

The provider had failed to seek and act on feedback from people and staff for the purposes of continually evaluating and improving the home. Residents and relatives meetings' were held every six months for people living in the home. These meetings were to provide people and their relatives with an opportunity to discuss their concerns and raise issues. We found however that these meetings were unannounced and undertaken after a lunchtime meal. There was no agenda distributed beforehand.

People told us they did not have an opportunity to raise issues to be put on the agenda or plan and discuss amongst themselves what they wanted to raise at the meeting. A relative also commented that because these meetings were not advertised they did not have an opportunity to attend and get involved on their relative's behalf. We looked at the minutes from these meetings and found that there were ongoing issues in relation to the food menus. People also told us that they didn't always receive

Inadequate

Is the service well-led?

feedback for any requests that they made. We found that actions were not recorded as part of a formal auditable action plan, which meant we were unable to check that all actions had been completed.

There were no staff meetings, survey or quality assurance process in relation to staff which enabled them to share their views with the provider. Staff told us that the registered manager and provider would listen to their views and that they felt able to raise concerns or issues. However this did not necessarily mean their views would be taken into account. For example, the staff had previously raised issues about the lack of a lockable medicines trolley and the food menu however no action had been taken by the provider.

We also asked the senior staff for the call bell audits for the last month, the complaints folder and the home quality assurance surveys for the last year. We were told that these records could not be located.

These failings amounted to 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had failed to ensure that the home was secure and clean for people. This was a breach of Regulation 15 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The home was not suitably clean and people were at risk from poor hygiene practices. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not ensured that staff were of good character and suitably competent for the positions applied. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

There were not sufficient numbers of staff to support people safely.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to provide staff with supervision and training to enable them to carry out the duties they were employed to perform.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure that people sustained good health by the means of providing suitable nutritious food and hydration. The provider had failed to ensure that people sustained good health by the means of meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences. These amounted to breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not receive person centred care that was appropriate and met their needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate the risks relating to people's safety and health. The provider had failed to assess, monitor and improve the quality and safety of the service to people. The provider had failed to seek and act on feedback from people and staff for the purposes of continually evaluating and improving the home. These amounted to breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to make appropriate notifications. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that there were systems and processes operated effectively to prevent abuse of people. The provider had not met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). These amounted to breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning Notice