Barchester Healthcare Homes Limited

Adlington Manor

Inspection report

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Ratings

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

Overall summary

The inspection took place on 12 and 20 March 2015 and was unannounced. When Adlington Manor had been inspected prior to this in April 2014 it had been found to be compliant with all the regulations which applied to a service of this type.

It is a condition of the provider's registration that Adlington Manor has a registered manager. 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.

There was no registered manager at Adlington Manor when we inspected the home because they had just left to work in another part of the country. When we visited, the manager who was in post had been there for nine days. We were satisfied that steps were being taken to ensure that this person registered as a manager.

Adlington Manor is part of Barchester Healthcare Homes Limited and is registered to accommodate people who require nursing care and support with personal care. Care is provided in two units one of which (the Rowan unit or Memory Lane) provides specialised care for people living

Summary of findings

with dementia. The other unit is called Cedar unit and provides care for people who have more general nursing requirements. The home is located in a rural part of Cheshire between Macclesfield and Poynton.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which now correspond to 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 this report.

We found significant differences between the care provided in the Rowan unit and the Cedar unit. On the former we found that there were insufficient staff and that medicines were not administered correctly.

Arrangements around mealtimes and for people to receive food and drinks were not adequate and some people were not provided with the care and treatment they required.

We found that the environment required improvement for people living with dementia and quality assurance and monitoring systems were not developed sufficiently to be effective. These were all breaches of the relevant regulations.

During our inspection we found that the provider took steps to make sure that staff were recruited safely and that they were provided with training so that they could do their job. In some parts of the home people who used the service were provided with activities if they wished them and within an environment which was supportive and pleasant including a positive dining experience.

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?

The service was not safe because the registered person had not deployed sufficient numbers of suitable staff. We found that the registered person had not provided for the proper and safe management of medicines.

We found that the provider took adequate steps to make sure that people who worked in the home were suitable to do so. The home was clean.

Inadequate

Is the service effective?

The service was not effective because the arrangements for helping to people to eat and drink were not satisfactory. People's rights under the Mental Capacity Act 2005 were not being upheld.

There were good arrangements for staff training and an appreciation of the need to deal with unexpected or unusual behaviour in a way that was not challenging or threatening.

Inadequate

Is the service caring?

The service was not caring because some staff did not respond to people who used the service in a way that was caring and considerate. Not all the people who used the service were provided with proper care including care of their clothes and their personal grooming.

People's requests for help and assistance were sometimes ignored. People's rights to dignity and privacy when receiving medical examinations were compromised.

Inadequate

Is the service responsive?

The service was not responsive because the environment was not suitable for people living with dementia. Parts of the home were not well lit and people were not encouraged to make use of all the facilities which were available.

Care planning documentation was not always complete and there were few activities for people living on one of the units.

Inadequate

Is the service well-led?

The service was not well-led because the systems or processes which operated to assess, monitor and improve the quality and safety of the service were ineffective.

Staff received supervision and the new manager was holding meetings with people who used the service, their relatives as well as staff. The new manager was aware of what we had found and was committed to improving the service.

Inadequate

Adlington Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 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 12 and 20 March 2015 and was unannounced. We carried out this inspection because we had received information of concern relating to the management of medicines.

The inspection team was made up of two adult social care inspectors and an adult social care inspection manager, together with a pharmacy inspector and a specialist adviser with expertise in the Mental Capacity Act 2005. On the second day one adult social care inspector returned together with 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 in this case for people who are living with dementia.

Before the inspection we reviewed all the information that we already held about Adlington Manor. We asked the local authority to provide any information they held and made the same request of the local Healthwatch group.

We talked with 10 people who used the service and seven of their relatives together with 15 staff who worked in the home. We talked with the manager as well as other senior staff from Barchester Healthcare Homes Limited. These staff were supporting the manager whilst she was new in post.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around the building and facilities and with their permission, looked in some people's bedrooms. We reviewed care and staff files as well as other documentation relating to the provision of care in the home.

Inadequate

Is the service safe?

Our findings

The people we spoke with told us they felt safe in the home. One person said "Yes, I'm safe" and another told us "I like it here but I'd rather be at home, but yes I'm safe. Staff are kind". Relatives confirmed this saying "(my relative) is safe. Everyone appears kind" and "Definitely safe. Staff are fantastic".

We spoke with another person who told us they liked living at the home and that staff were very nice. However, they also said that there were not enough staff. They told us that when they rang their nurse call bell to ask for help to go to the toilet, staff frequently said they would return in five minutes as they were busy and then they were waiting "five, ten or fifteen minutes".

We had concerns about the safety of care being provided to some people. For example, at 10 am we found that one person had fallen in their room. When we looked at their care records we saw that they had been assessed as at high risk of falls. Due to their level of confusion this person was unable to use their nurse call bell so a risk assessment stated that staff should check on them every hour when in their bedroom. When we looked at the chart which recorded staff checks we saw that this person had only been checked on at 5.35 am and 7.05 am.

One person told us that they had fallen in their room a couple of weeks previously and had been on the floor for two or three hours before they were found by staff. When we checked this person's care plan it stated that they should be checked hourly.

Accident records showed that this person had fallen five times between November and January. However the falls risk assessment for this person had not been updated between the end of December and the end of February and none of the falls except one had been recorded on the person's fall diary. Staff had used a generic care plan relating to prevention of falls on which they selected the interventions that applied for this person from a pre-printed list. This care plan had been completed in August 2014 but not updated since. This meant that effective measures were not in place to monitor the falls this person had and to take steps to reduce the risk.

We were concerned about the levels of staffing in the Rowan unit. We were told that on the day of our inspection there were five care staff, one of whom was a team leader together with the unit manager\nurse in charge. However we were advised that the usual staffing level for each unit should include two nurses. The home had been dependent upon agency staff but these had not materialised on the first day of our inspection.

This level of staffing was not sufficient to support the people who lived on the unit. We found that a number of people who were still in bed and had received neither food nor drink by late morning. A high percentage of people living on the Rowan unit appeared to require help with most of their personal care and many needed the help of two staff members. We checked all of the people on the unit at 8.45 am and found that 15 were still in bed and many seemed asleep. Two people were out of bed but in a state of undress and looking for staff to help them. At 9.45 am we found that 10 people were still in bed in the dark and at 10.45 am we found that seven people had still not been assisted with a wash, breakfast or drinks. For most of the morning those people who were out of bed remained in the dining room and apart from a hostess (who was employed to assist with meals and is not a member of direct care staff) staff were not readily visible.

We saw that on the Cedar unit staff were attending to people throughout the morning and either serving them food and drinks in the dining room or were taking breakfast trays to them in their room. As these tasks were completed people gradually joined other people in the communal lounge.

We saw that the nurse in charge on the Rowan unit was preoccupied with administering medicines but was interrupted whilst doing so because care staff needed their assistance. This meant that people received their medicines late (which may affect their efficacy) because the nurse was delayed and there was a heightened risk of medicines errors. The nurse was distracted and diverted from their task because care staff asked for help for people living at the home. For example when we found someone had fallen in their room we alerted a member of care staff who then went to ask the nurse to come and assess the person for any injuries before they moved them. This meant that on the first day of our inspection some people did not receive their morning medicines until midday.

Although there was an additional member of nursing staff present on the second day the morning medicines round

Is the service safe?

was still not completed until after 11 am. This meant that medicines were not being administered at the times prescribed and could compromise the timely administration of the next dose.

We asked the manager how staffing levels were calculated and how they related to the needs of the people who were living in the home. She told us that dependency levels had last been calculated the previous September and provided us with a copy of the tool the previous manager used for this. She explained that since she had arrived at the home only very recently she had not had the opportunity to recalculate them. She had continued with the arrangements she had found when she took over.

This meant that the registered person had not deployed sufficient numbers of suitable staff. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see if the registered provider took care to make sure that people were suitable to be employed in the home when they were recruited. We looked at five staff files and found evidence that required checks had been made including Disclosure and Barring Service (DBS) checks (which allow an employer to take any criminal convictions into account) and appropriate work permits where required. The registered provider had systems for renewing DBS checks and for checking nurses PIN numbers to make sure they were currently registered to practise.

We looked at the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stocks and other records for thirteen people on the Rowan unit. All medicines were administered by qualified nurses. We observed part of the morning medicines round on both units. The medicines administration records were completed at the time of administration to each person, helping to ensure their accuracy. However, arrangements were not in place to ensure that people received their medicines at the best and right times, in order that they would receive the most benefit from them.

The medicines administration records were clearly presented to show the treatment people had received.

Written individual information was in place about the use of 'when required' medicines to assist nurses in their decision making. Where the covert (hidden) administration of medicines was used we saw some evidence of GP and family involvement in the decision making. However, appropriate safeguards were not in place to ensure that people's best interests were protected. Contrary to current guidance records of assessments of capacity and of the decision making process were not in place and kept under review.

Three of the records we looked at showed that people were regularly refusing one or more of their prescribed medicines. There was no evidence to show that prompt advice had been sought, in order that their treatment could be reviewed by a doctor. Clear records of GP advice were made when new medicines were prescribed and these were promptly started. However, we saw one example where a dose of medicine had been increased but the changes to that person's medicines administration record did not match this in the record of GP advice. Prompt action was taken to clarify this when raised with the nurse. We were not able to check whether people's records had been correctly updated on their return to the home from hospital because staff were unable to find two recent hospital discharge notes.

We found that the registered person had not provided for the proper and safe management of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulations 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the home and saw that it was clean and tidy. One relative told us that they were very happy with the cleanliness of the home and added that "I frequently check (my relative's room and it is always clean and tidy". Another relative invited us to visit a person's bedroom. We saw that it was well furnished and decorated and there was an en suite toilet. Both the bedroom and toilet were clean and the room smelt fresh. The room had been personalised with family photographs and a television.

Inadequate

Is the service effective?

Our findings

We asked people about the food in the home and were told "I like the food but not always", "It was lovely curry but there wasn't a lot of it" and "Food's OK. I had some grapes and strawberries this morning". We noticed a marked difference in arrangements between the two units. In Cedar unit the tables were neatly laid out with cruet, flowers and menu cards on each table. In Rowan unit the tables were not laid and there were no menus. When we asked one person if they knew what was for lunch but they told us they did not know. However, they said the food was "always quite nice, I've never had any grumble."

We looked at the arrangements for nutrition at the home. In Cedar unit a breakfast of cereals with toast and preserves and an optional full English breakfast was available. The menu stated that if people preferred something else then the kitchen "will do our best to meet your needs". We saw staff preparing breakfasts which they took to some people in their bedrooms on trays and to others in the dining room. We saw that there was clear information about people's dietary requirements and allergies and the different textures which were required for people whose swallowing difficulties meant they needed their food to be pureed. We saw that the kitchen took care to prepare pureed food in such a way as to preserve the different colours and flavours of different foods as par as possible. We saw these staff preparing thickeners for drinks where these were required.

The lunch menu included soup, a choice of main course, and a pudding with ice cream. At supper there was a further choice of a hot meal or salads together with a dessert. The menu noted that cheese and biscuits were always available. We were told that some people preferred cheese and biscuits to a full meal but that supplies of these regularly ran out usually on a Tuesday. People had to wait until a new delivery arrived.

We also spent time in the Rowan unit dining area which had an open plan servery staffed by a dedicated member of staff designated as a hostess. Their role was to prepare breakfasts, plate lunch that was prepared in the main kitchen and provide drinks and snacks throughout the day. We saw that this might provide ready access to helpings of food and drink in between meals. However we were concerned that this did not take into consideration people who were unable to make this decision or whose mobility prevented them from accessing this facility. Throughout the course of the morning we did not see an alternative such as a tea trolley in evidence, which meant there was a risk that some people might not receive a drink all morning. On two occasions we heard people call out for "a cup of tea" but they were not heard by the staff.

We found on both days of our inspection that lunch in the Rowan unit took two hours to complete. People were all brought into the dining room before the meal started to be served. Choice was facilitated by offering people the two dishes which were available. People with dementia might be more likely to make a realistic choice this way because they might otherwise have forgotten a choice they made some time before. However in one instance we saw that someone was only offered the meal that had been rejected by another person. Staff corrected this at the person's request.

Not everyone could fit in this dining room and so some people stayed in the lounge for lunch. Some of these people needed assistance with eating but we saw no staff in the lounge during the lunchtime period. We saw that one person in the lounge was trying to eat whilst slumped in her chair. This person's plate was on her lap and they were having difficulty spooning the food into their mouth. As a result food was spilling down this person's clothes. Another person was eating from a tray table but was experiencing difficulty without any help from staff.

We had concerns about how some people's nutritional needs were being met. For example, we met one person living on the Rowan unit who appeared quite thin and frail. We looked at their care plan and saw that they were prescribed supplementary drinks four times a day. We observed this person throughout the morning but they were not offered any of their supplementary drinks. We saw this person at 11.40 am and they told us they were thirsty. The last entry on their chart stated that they had been given a cup of tea at 9.15 am It was not possible to account for the storage and administration of prescribed supplements in this unit. We saw that records showed that one person had been given supplements over a fortnight but they had only been prescribed over one week. None were found in stock on the day we visited.

We saw that another person living on the Rowan unit was not offered any breakfast or drinks and they were not assisted to get up until 12 noon When we looked at their care plan we saw that they had been identified as at risk of

weight loss. Their care plan stated that they needed snacks between meals, supplementary drinks and to be weighed weekly. The last weight recorded was at the beginning of the month of our inspection and when we checked with the nurse she was unaware that this person's weight needed to be monitored weekly. Records were not readily available at first but when they were provided on the second day of our visit we saw that the next entry was more than two weeks later and this person had lost weight.

Another person had no care interventions until 11.20 am We were with this person when a carer came in. We asked if the person had been given any breakfast and they said "not yet, no." When we checked the care plan for this person we saw that they had lost significant weight. Some explanation was given for this, however, the care plan had not been updated and we had concerns about the length of time this person went between meals, when they were very underweight with a body mass index (BMI) that had dropped from 16 to 14. BMI is a measure of body fat based on height and weight that applies to adults and is used to monitor wellbeing particularly in older people especially where living with dementia may interfere with nutrition. The BMI for normal weight starts at 18.5 and anything under this is considered underweight.

During lunchtime and after some time one person got up and left the table with their main meal uneaten. This appeared to go unnoticed by staff who did not give this any attention or encouragement to this person to return. This meant that this person was not supported to eat and drink. When this was drawn to the staff's attention we were told that it would be recorded, but there was no reference to any contingency which would have compensated for lack of food (for example whether this person would be offered something else, or asked later about eating something). When we returned on the second day of our inspection we saw that no record had been made of this person's failure to eat. Instead the record showed that at lunchtime they had eaten a full two-course meal which was incorrect and would have misinformed other staff about their needs.

We found that the registered person had not met the nutritional and hydration needs of people who used the service. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements for training staff at the home so that they had the skills to provide care for people. We saw that the home had a dedicated training area with a member of staff who organised and administered the training. We saw that there was a five day induction programme during which staff received training in topics such as infection control and manual handling, as well as safeguarding and the requirements of the Mental Capacity Act 2005. Other staff within the home such as the cook and the housekeeper had also contributed according to their specialisms. The induction programme had recently been extended to include time for staff to spend shadowing more experienced staff in the home.

When we spoke with staff they confirmed that they had undertaken this programme and referred back to it when describing how they would respond to any safeguarding issues. They demonstrated an awareness of what to do. We saw from staff files that other training which had been undertaken included in dementia and behaviour and diversion techniques. More senior staff had undertaken courses in supervision and appraisal.

People who are living with dementia can sometimes behave in a way that is unusual or unexpected. We asked staff if they received any training to deal with these sorts of situations and specifically if the used any form of restraint. One member of staff told us "We do not use restraint here - staff are trained to use NAPPI (Non Abusive Psychological and Physical Interventions)". The purpose of this technique is to enable staff to remain calm, supportive and professional, while utilising skills to deal with the behaviour in a way that does not provoke the person further.

Although we did not witness any such interventions we saw that within the care plans for mental health there were clear descriptions of "triggers" that might be a catalyst for such behaviour. This was accompanied by guidance on how situations should be de-escalated, and managed further if necessary. However because this information was embodied with other information it was not as readily accessible as it could be. Nevertheless this meant that staff were both trained in and had some access to information that would assist them in both identifying and responding appropriately to situations that could potentially be unsafe.

We had concerns that the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

Inadequate

Is the service effective?

(DoLS) were not being followed. These arrangements provide for the protection of people who are no longer able to make a decision for themselves usually because of an illness such as dementia.

We saw from one person's daily records that they repeatedly asked to go home. Other parts of this person's records indicated that they had some level of capacity. There was no evidence of a best interest meeting being convened to discuss this. There was also confusion as to whether a DoLS was in place for this person and the staff member had recorded that they had referred the matter to social services (who are the managing authority which can grant the DoLS). However, this did not appear to have been followed up so the situation remained unclear. We talked to another relative who was very satisfied with the care provided but who told us that every so often their relative said "Get me out of here". There had been no best interest meeting for this person neither had consideration been given to offering them the safeguards afforded by DoLS.

We saw that several other people were subject to DoLS authorisations. In two cases the time period for the authorisation had expired. Staff had not ensured that a review was held for these people and a decision made as to whether the authorisation should be continued. People who are thought to no longer have the mental capacity to make certain decisions must be given a capacity assessment and if required have certain decisions made by a best interest meeting. Where a person does not have capacity and their liberty is being restricted then they must be provided with the safeguards provided by DoLS. Otherwise they might be detained without the authorisation to do so which is a breach of their human rights.

Mental capacity assessments for other people were not complete or had not been carried out in an appropriate way. For example, one person had a capacity assessment for a decision as to whether they could go into the grounds of the home. The assessment appeared to have been completed by the GP and stated that they hadn't spoken with the person's next of kin directly but had been told by staff that the relatives were in agreement with the decision.

We found other concerns relating to the implementation of the Mental Capacity Act 2005 in the home. Not all care files had a capacity assessment on them but one we saw had an assessment with the phrase "Doesn't have any mental capacity to make any decisions", We saw that the service was using a pro forma devised by the registered provider. This required only the completion of check boxes to confirm the outcome of the required tests rather than an account of how the person had responded during the assessment. The Code of Practice for the Mental Capacity Act 2005 outlines the requirements to be observed in this respect.

This meant that that the registered person had not acted in accordance with provisions of the Mental Capacity Act 2005. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection we saw that the manager had taken steps to correct the position relating to DoLS and met a best interest assessor and medical practitioner who were visiting the home to complete assessments on behalf of the local authority.

Inadequate

Is the service caring?

Our findings

One person told us "Staff are kind". During our inspection we talked with relatives who visited the home. One told us "Definitely kind and caring even though it is a stressful job – (the staff) are patient". Another said "Lots of lovely caring staff, quite genuine, some here a long time". Other comments included "They (the staff) do a very good thing in difficult circumstances".

We asked if they felt involved in the care of the people they were visiting. One relative said "Involved? Yes indeed. They (the home) always ring me and keep me informed but then they take the action. They did ring me because they were concerned that (my relative) needed new slippers, as because of swollen feet the ones they had were not fitting properly, and I provided these. I have no complaints or concerns. We pay (the private fee for the home) but I think it is good value for money". Another told us "They involved me in how they would care for (my relative)"

One relative told us "Last week, we were told (my relative) was not going to make it, but this is wonderful she is getting better and starting to eat". A fourth relative was visiting Cedar unit and told us that they had experienced variable care in similar homes and had even considered using covert surveillance in them but had no concerns about this service. They told us that they were very satisfied and felt the care provided was good.

We saw that in these instances relatives were very much welcomed by those staff in the home they came into contact with. One was greeted and received warmly by a hostess in the dining room and promptly provided with a hot drink. In another instance the visiting relative was clearly familiar with and known to the people living in the home. We saw one visitor who had returned to see the staff although their relative was no longer living in the home. It was clear that a very warm and genuine relationship had developed whilst this relative had been living there.

We noticed a marked variation in the way that staff related to the people who lived in the home. We saw that some staff were enthusiastic and spoke energetically about their work. One told us "I love it here, I have never worked anywhere like this before and I love it, these people are my boss and I look after them". On Cedar unit we saw a member of care staff taking care and patience in helping someone to eat. They offered people choices about whether or not they wanted ice cream with their sweet. Some other staff in the home interacted with the people who used the service but in a very task-centred way and with no spontaneous conversation that we could see. Some staff were actually quite sullen and in another part of the home one appeared totally disinterested in their task of feeding a person who was unable to do this for themselves. They spent most of the meal looking around the room.

Early in the morning we saw one person upstairs on the Rowan unit. This person said they did not feel well and they looked unkempt, with dirty teeth and lips, uncombed hair and ill-fitting clothing. Later we saw this person with a member of care staff. They were still extremely unkempt but the carer made no mention of this and only offered to get the person a cup of tea. At lunch time we saw this person again, still wearing the same trousers, which were falling down and wet at the bottom. We had to ask staff to help this person to change their clothing as they did not seem to be aware that any care interventions were required.

There did not appear to have been recent attention to grooming. For example we saw that that two people had substantial hair growth on their chins, in one case at least two inches long. We had seen photographs of one of these people as a young person and felt confident that they would not have wished to appear like this. Although they were not able to express this for themselves we felt sure that if they had been able to then they would have felt this appearance to be undignified.

On Cedar unit we heard one person shouting in the toilet. We noticed that several members of staff walked past without responding. We went to speak with this person and they said they had been "shouting for ages". The light in the room was operated by a movement sensor and the light had gone off and the sensor had not detected movement so the person was sat in the dark. This person was distressed and anxious trying to alert staff that they needed help.

We overheard staff assisting one person, behind closed doors. This person sounded agitated and was shouting and saying they would hit the staff. We heard that the staff were patient and remained calm and spoke kindly whilst trying to gain their cooperation.

We undertook our SOFI in the lounge area of Rowan unit on the second day of our inspection when it was better staffed.

Inadequate

Is the service caring?

We saw that whilst there were a number of staff available they did not always seem to relate effectively to the people who lived in the home. Some people received attention but others did not. One person was crying out. The first member of staff told them "I will attend to you just as soon as I have had a wee", went to the toilet and then walked past this person without attending to them on their return. A member of nursing staff then entered the lounge and acknowledged the same person who was still shouting. They said they would attend to them after they had been in the nurse's office. We did not see them come out of the nurse's office to do this. The person asking for attention was eventually attended to by a nurse who was visiting from another unit.

We spent some time sitting in the secure garden with one person. Whilst we were doing so we saw three members of staff taking a break. Although they saw this person they did not acknowledge them in any way but started giggling amongst themselves. We found this to be exclusive in not acknowledging this person.

This meant that the registered person had not provided people who used the service with care and treatment which was appropriate, met their needs and reflected their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that on each unit care files were kept in an office. This meant that they would not be accessible to people such as visitors who were not authorised to look at them.

People could be confident that their information was kept in confidence. We saw that people who lived in the home received a visit from a GP service. We saw that there was good liaison with nursing staff as the doctor visited the people who needed to be seen throughout the home. However we saw that one of these consultations and examinations took place in the dining room during the lunch period with other people and staff present. This did not preserve this person's dignity and compromised confidentiality as well as their privacy.

When we looked at Deprivation of Liberty Safeguards (DoLS) authorisations we were concerned to note that in one instance a "relevant person's representative" (RPR) had been appointed by the local authority. In other instances no RPR had been appointed. An RPR fulfils important advocacy functions for a person who is subject to a DoLS but we saw no evidence or record that the provider had acted upon this or queried the absence of such an appointment by the local authority. Every person deprived of their liberty through DoLS is entitled to an RPR to maintain contact with them, to represent and support them, request a review on their behalf or provide independent support. This meant that people subject to DoLS might be deprived of an advocate.

We saw that the provider had implemented a recognised care pathway for people who were nearing the end of their life. The aim of this pathway was to ensure all people receive high quality end of life care provided by a care home that encompasses the philosophy of palliative care. We saw that training in this pathway was included in the provider's training plan.

Inadequate

Is the service responsive?

Our findings

Relatives told us that they saw recent changes in the care provided at Adlington Manor. One relative told us "Lots of improvement lately – new furniture". They told us that they had found staff responsive. One relative told us "When (my relative) was poorly it was difficult for them to eat so they tried them on yoghurt and told us to help ourselves from the fridge". Another relative told us that they had been concerned that their relative did not have a food and fluid chart and had discussed this with staff. They told us that the matter was resolved.

We found that the quality of assessments and care information about people living at the home was variable. Care plans were, in general very detailed and personalised and most had been reviewed at least monthly. However, when staff had reviewed some care plans they had not referred to incidents and events that had happened since the previous review. For example, where people had fallen or people had lost weight it was not always reflected in the record.

The assessments for some people were only partly completed. For example, one person's mental health assessment was not completed, although elsewhere in the records they were reported to have unpredictable behaviour. Another person did not have an assessment completed at all. Staff would not always be able to rely on these records in order to provide the most appropriate care for people who lived in the home.

We saw that one person had a visible wound that had a soiled dressing on it. When we looked at the care file we could not find any assessment or care plan relating to this wound and we were unable to determine when it was last dressed. We later saw that a member of staff had removed the dressing, leaving the wound undressed. The wound looked sore and the person told us they had rolled up their sleeve, as it was rubbing on their clothes.

We were told that a significant number of people in the home were living with dementia and we looked at the ways in which the home responded to their specific and individual needs such as through meaningful activity. We saw that there was an activities organiser in both units. The activities organiser in Cedar unit was working with one person in the conservatory and was preparing for "red nose day" whilst chatting to this gentleman. On another occasion an external performer was providing a music and armchair exercise session in the main lounge. The organiser told us that they found out about people's preferences by talking to them. We saw that other activities included gardening, baking, visits from the hairdresser and crafts. A trip out was organised each Monday. We saw this activities organiser working her way around other parts of the unit where there were other lounges.

We did not see the same activities on Rowan unit but we did meet an activities coordinator who had been recently appointed for that unit and whose first day at work was the first day of our inspection. This member of staff had undertaken dementia awareness training in their previous employment. They told us about their ideas about what they would like to offer but said that at first they would be spending time getting to know the people who used the service, and speaking to staff about what they thought would be welcomed in the way of activities. We saw that they were prepared to assist directly with the care of people and were told that this appointment might remove the responsibility for activities from staff who had not had the time to develop them properly. At the time of our inspection however we saw little opportunities for individual or group activity and most interactions with people seemed to be task rather than person-oriented.

This meant that the registered person had not provided people who used the service with care and treatment which was appropriate, met their needs and reflected their preferences. This was a further breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have already mentioned this breach in the "caring" section of this report.

We asked if the home monitored the timing of responses to the call bell system but initially were told this was not the case. Subsequently a member of staff showed us how this was possible and we reviewed response times for both units. These showed that staff generally responded to calls for assistance via this system within five minutes. However these calls would be limited to those people who were in their bedrooms. During the day most people were in the communal areas of both units and would not use the call system to summon assistance.

We saw that at lunch times and in the afternoon staff generally responded quite promptly to the needs of people

Inadequate

Is the service responsive?

who used the service. However on occasions such as lunchtime in Rowan unit we saw that some staff missed the opportunity to interact with people and either passively observed what was happening or talked amongst themselves. Because of the protracted arrangements for serving lunch in this unit this meant that the opportunity to reassure people about what was happening was sometimes missed.

We looked at the building and physical environment of the home to see how this had been adjusted to respond to the needs of people living with dementia. Physical environment can assist people who are living with dementia by providing use of colour and lighting and signage to help people to find their way around. We saw that different carpet colours had been used in the Rowan unit along with different coloured bedroom doors with clear nameplates and numbers on them. Posters with historic items which might be of interest to people were displayed in the corridors. However the corridor lighting was poor generally and in one corridor particularly so such that any benefit from this approach was likely to be limited or lost entirely.

We saw that whilst there were two comfortable lounges in this unit together with a large activity area, they went largely unused by the people who used the service who were located principally in the dining room with some people sitting in chairs immediately outside the nurse's office. These areas were sparser and less comfortable than other unused parts of the unit. They were closer to the locked doors which were controlled by key pads and so emphasised the restrictions on people's movements. We saw and heard both a radio and television in use at the same time on this unit. Extraneous noise is unhelpful to people living with dementia.

This meant that the registered person had not provided suitable premises for the people who used the service. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there was a garden area available for use by people and the manager told us that she had secured the funding to make developments in this part of the home with the aim of making it more dementia-friendly. We looked at the arrangements for the maintenance of the building and the equipment in the home. We saw there was a team of three staff and were shown around their workshop facilities. Most maintenance tasks around the home could be undertaken by this team and during our inspection we saw them replacing joinery around the building. We also heard about the current manager's plans to change some of the spaces in the home and how the maintenance team would be involved in implementing these changes.

We checked various maintenance schedules and found they were up to date. They included a weekly check of a different three bedrooms in turn and across a range of items such as the functioning of equipment, water temperature and the state of the furniture and fittings. In general the high quality of the maintenance of the physical environment of the home reflected this attention to detail.

Because of its rural location the home is not permanently connected to the national grid for electricity and the supply can fail from time to time. We were told that had last happened in the last few weeks and that the agreed contingency arrangement had taken place. The home has sufficient batteries to provide emergency power until an emergency generator is provided. The requirement was that the emergency generator would be supplied within one hour of the failure. This was important because whilst using batteries certain systems would not function including the call bell system that people used to summon assistance.

Inadequate

Is the service well-led?

Our findings

Adlington Manor is required to have a registered manager. The most recently registered manager had moved to another home in the same group and his registration in respect of this home had been relinquished. The current manager had applied to the Care Quality Commission (CQC). We were satisfied that the provider was taking steps to comply with this requirement.

In addition to the registered manager having left the deputy manager had also recently taken employment elsewhere creating a vacancy which was still unfilled. At the time of our inspection the new manager who had experience of managing similar homes had only been in position for a matter of days. She was receiving mentoring support from the registered manager of another nearby home from the same company. In the interim staff told us "It's just been a number of changes. First one manager, then another". One member of staff described the interim period of management as very reactive, responding to immediate issues without any longer-term planning. Some staff were visibly upset by our visiting during this period and sought to reassure us that what we found was not representative of the home. Staff told us that they had found this to be a difficult period and said they were looking forwards to the stability which might be provided by a new manager.

We checked records of supervision for the home for the last twelve months. Supervision is a meeting that takes place in private with the person's immediate manager to discuss their training needs and any issues of concern. We saw that these had taken place usually monthly and included discussion of performance issues and training as well as overall staff wellbeing. We saw examples of where staff had voiced difficulties and management had put in place arrangements to meet those difficulties. There was also evidence of other forms of supervision such as end of probation reviews and some appraisals although we were advised that given the recent disruption in management arrangements that these meetings were probably not up to date. We were told that this had been acknowledged and that management action was in hand to bring them up to date as well as improve the current systems of recording.

We saw that the manager held a daily meeting with all the heads of departments. We attended one of these meetings and saw that they were brief but that each head of department outlined the key challenges for the day such as the need to provide escorts for people who were going out to appointments, provide supplies for activities and any other items of interest. The manager told us that she was planning to introduce a meeting for other staff so as to encourage communication and make sure that any issues were brought into the open and discussed.

We also saw that meetings had been held with people who used the service at which representatives from both units had attended. There were also meetings held every other month for relatives with the meeting time alternating between morning and afternoons so as to maximise attendance. We saw minutes for all these meetings which showed that they had last taken place in January 2015 and were told that the minutes of relatives' meetings were distributed to all relatives whether or not they were able to attend.

We saw that the registered provider had a system of quality audits and were provided with the most recent one from December 2014. The audit was detailed and designed around the same Care Quality Commission (CQC) framework as is used in this report. We reviewed this document after the end of our first day of inspection and found that it identified a number of similar issues as had become apparent to us. We also saw a number of other recent audits which had been completed in relation to kitchen and housekeeping and communal living experience.

Whilst some of challenges identified in these audits such as recruitment and culture will require longer-term change action could already have been taken to remedy others. For example the observations of lunchtime on the Rowan unit were similar to those we have described in this report but no effective action seemed to have been taken to resolve the shortfalls which had been observed. They were mentioned again in a further audit undertaken at the end of January 2015 but again no effective action appeared to have been taken by the time of our inspection. Previous instances of carers ignoring people's requests for help or promising to help them but not returning to do so were also recorded. A similar example of clinical discussion and examination with a GP in the dining room had been reported on an earlier occasion but no obvious action had

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Is the service well-led?

been taken to prevent a recurrence. The audits had not been effective in producing action plans which were then implemented so as to improve the care of people who were living in the home.

This meant that the registered person did not have systems or processes which operated effectively to assess, monitor and improve the quality and safety of the service. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is required to notify the CQC of certain events that might take place at the home including accidents. We reviewed the information that we held and were satisfied that the registered provider was notifying the CQC appropriately. We also checked the complaints register. Although the CQC does not deal directly with complaints we were satisfied based on our knowledge of the home that it reflected complaints which the home had received and dealt with. On certain occasions the CQC receives information which it shares with the local authority safeguarding team. Whilst we were undertaking this inspection we met the local authority officer who was responding to information we had provided and were satisfied that the home had responded appropriately.

We saw that there were bi-monthly visits by the regional director on behalf of the registered provider and that the last of these had taken place in October 2014. The findings had been incorporated into a central action plan of which we were provided with a copy.

We fed back some of our immediate concerns to the registered manager after the first day. When we returned for the second day of our inspection the provider had drawn up an action plan to show us how they intended to respond to these concerns and committed to revising this plan in the light of the rest of our findings. Given that the manager was so new in post we found her to be open and transparent about the concerns we expressed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had not provided suitable premises for the people who used the service.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not provided people who used the service with care and treatment which was appropriate, met their needs and reflected their preferences.**

The enforcement action we took:
We have served a warning notice to be met by 17 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not acted in accordance with the provisions of the Mental Capacity Act 2005.**

The enforcement action we took:
We have served a warning notice to be met by 17 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not provided for the proper and safe management of medicines**

The enforcement action we took:
We have served a warning notice to be met by 17 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person had not met the nutritional and hydration needs of people who used the service.**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have served a warning notice to be met by 17 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have systems or processes which operated effectively to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:
We have served a warning notice to be met by 17 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not deployed sufficient numbers of suitable staff.

The enforcement action we took:
We have served a warning notice to be met by 17 August 2015.