Adiemus care ltd

Ravenscroft

Inspection report

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Ratings

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

Overall summary

Ravenscroft provides accommodation which includes nursing and personal care for up to 46 older people. At the time of our visit 20 people were using the service. The bedrooms are arranged over three floors. There are communal lounges and a dining area on the ground floor with a central kitchen and laundry. Ravenscroft is managed by Adiemus Care Limited which is part of a larger national organisation, Orchard Care Homes.

Whilst there was a registered manager employed by the service, they were currently on long term leave. The home was being overseen by an interim manager and the clinical nursing lead. 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.

Summary of findings

People were not always protected by the prevention and control of infection. Whilst there were systems in place to reduce the risk and spread of infection staff working in the service did not consistently comply with infection control practices.

Medicines were not always managed safely or stored safely. Medicines were not always available to people.

People receiving a service were not always protected by safe recruitment and selection processes. Information relating to past employment and behaviours were not always recorded in people's personnel files.

Regular meetings were not held between staff and their line manager to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home.

People were not always supported to have sufficient to eat and drink. Records did not clearly identify if people were being supported to receive sufficient to eat and drink.

We found the service was not meeting the requirements of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards. Where people were deemed as lacking capacity assessments did not evidence how this staff came to this conclusion.

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse.

There was evidence of regular consultations with health care professionals where needed and people's healthcare needs were regularly monitored.

People and their relatives spoke positively about the care and support they or their relative received.

We found staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals. Staff knew about people's likes, dislikes and preferences

Staff were motivated and caring. Staff were positive about the support the received from the interim manager.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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

This service was not safe.

People were not always protected by the prevention and control of infection.

Medicines were not always managed safely or stored safely.

People were not always protected by safe recruitment practices.

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse.

Is the service effective?

Requires Improvement

This service was not always effective.

Staff did not have access to regular supervision and appraisal to support their personal development.

People were not always supported to have sufficient to eat and drink.

We found the service was not meeting the requirements of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed

Is the service caring?

Good

This service was caring

People received support in a caring and sensitive manner.

People and their relatives spoke positively about the support they or their relative received.

We found staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals.

Is the service responsive?

Requires Improvement

This service was not always responsive

We looked at ten care plans and found that some guidance did not always identify how care and support should be provided. This meant that people were at risk of not receiving the care and support they needed.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. Most people were confident their concerns would be listened to and appropriate action taken.

Is the service well-led?

Inadequate

This service was not well-led

Summary of findings

The provider did not have effective systems to monitor the quality of service to ensure improvements were identified and acted on.

Staff were aware of the providers values. They were motivated and caring.

Staff were positive about the support the received from the interim manager.

Ravenscroft

Detailed findings

Background to this inspection

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

This inspection took place on 10, 11 and 14 September 2015 and was unannounced. Two inspectors carried out this inspection. During our last inspection in May 2014 we found the provider has not satisfied all the legal requirements with infection control. The provider wrote to us with an action plan of improvements that would be made. We found on this inspection the provider had taken steps to make some of the necessary improvements that were identified during our last inspection.

We spoke with seven people living at Ravenscroft and six visitors about their views on the quality of the care and support being provided. 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 spoke with the Interim manager, project manager, clinical lead and ten staff including agency staff, a kitchen assistant and housekeeper. We reviewed a range of records which included four care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day. We also spoke with three health and social care professionals the home worked alongside.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Inadequate

Is the service safe?

Our findings

People were not always protected by the prevention and control of infection procedures. During our last inspection in May 2014 we found the provider has not satisfied all the legal requirements with infection control. The provider wrote to us with an action plan of improvements that would be made. We found at this inspection the provider had taken steps to make some of the necessary improvements that were identified during our last inspection. However there were still areas of improvement that had not been improved upon. The provided told us chairs that were stained had been identified and a replacement programme actioned. During this visit we found chairs in the communal lounges that were stained and dirty. Skirting boards remained damaged and difficult to clean.

Whilst there were systems in place to reduce the risk and spread of infection staff working in the service did not consistently comply with infection control practices. Hoist slings were shared between people, this contradicts the guidance issued by The Department of Health on the Prevention and control of infection in care homes (2013) which states 'slings should be laundered in the hottest wash cycle allowable according to the manufacturer's instructions and not shared between residents'. Hoist slings were hung from hooks in bathrooms and there was no information available for staff to indicate if slings had been cleaned or which person they should be used for. When we asked staff how often slings were washed they told us this happened weekly. However when we asked how they would know the slings had been washed they confirmed they would not know this information. This meant people were at risk of cross contamination because the slings were shared and there was no cleaning schedule in place.

We saw equipment such as hoists and safety mats were not clean. We observed two members of staff hoisting a person. The base of the hoist was visibly dirty. We asked them when it was last cleaned and they did not know. The provider's policy stated 'Hoists should be cleaned with hot soapy water between residents' and 'Hoist slings are for single resident use'. This practice was not being followed as identified in the provider's policy and procedure. We spoke with staff who told us there were not enough slings for each person using the service to have their own. The dirty equipment and the communal use of slings meant there was a risk of cross infection between people.

There were aprons and gloves available for staff to use. We observed staff wearing personal protective equipment and during discussions, staff were knowledgeable about their role in the prevention and control of infection. However feedback from staff on infection control practices within the home was mixed. For example one staff member said "Infection control is lacking here. Not enough responsibility is handed to staff" and "There are aprons and gloves available and I know when I need to wear them but I am not sure who cleans the equipment." Staff were not able to tell us how often hoists and equipment were cleaned or who was responsible for cleaning them.

There were processes in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which was completed by housekeeping staff to ensure that all areas of the home were appropriately cleaned. However there had been some staff shortages and there was evidence in the daily cleaning log that the premises had not been cleaned at all on some days.

This was a breach of regulation 12 (h) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some carpets and chairs in the communal areas were stained and dirty. Staff explained that as one of the carpets in the lounge area was so worn the carpet cleaner was no longer effectively able to clean it. They said the carpet cleaner was currently broken and had been for several weeks. This meant if any areas with carpets needed cleaning this had to be done by staff kneeling down and scrubbing the area by hand. This meant that staff's clothes could transfer infections from one place to another.

We observed that the carpet in one person's bedroom was heavily stained and had an unpleasant odour. The carpet in another person's room was torn and curtains in several rooms were not fully attached to the curtain rail. One person we spoke with told us their eyesight was poor. Their room had a light fitting with three bulbs, but one bulb was missing. They said "One bulb keeps blowing, but it hasn't been replaced".

Inadequate

Is the service safe?

We saw some areas of the home were damaged. For example skirting boards were chipped and worn, paint was peeling off the walls and door frames were damaged. This meant the cleaning of these areas was difficult.

All of the staff and all of the relatives spoken to said they had concerns in relation to the upkeep of the building. Comments included "My first impression when I came here, was what a dump" and "Some areas do need urgent attention, like doors that won't stay open and it needs decorating". One member of staff said "First impressions here are poor, it's shabby and it smells." Relative's comments included "They need to spend some money here to make some improvements" and "I'm really worried about the building; it needs a lot of upkeep, they had water coming in through the conservatory roof a while ago." Another relative said "The place might not look very good, but it's the care that counts."

One relative said "It's a bit of a worry because the lift keeps breaking down, so I do worry that X won't be able to come downstairs, or get back upstairs when they want to."

The garden area was well maintained and people were able to see it from one lounge and the dining room. Relatives said "It's a shame we can't get out to the garden, the path is uneven so it's not very safe".

These concerns were a breach of regulation 15 (1)(a) (2) (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed or stored safely. Those medicines, which required more secured storage, were stored in a cupboard that was not large enough to accommodate the volume of medicines in it. This meant medicines were disorganised, and when we observed staff administering these medicines to people, they had to remove the majority of items from the cupboard in order to locate the ones they were looking for. Within the cupboard we saw a box of pain relief, but the label was illegible. We showed the Clinical Lead and they informed us the ampoules (vials) would be disposed of in accordance with the provider's policy. The following day, the pain relief had been removed from the secure cupboard, but had not been disposed of and had been left on the side in the clinical room. The incorrect storage and illegible label increased the risk of misuse.

The provider's medicines policy stated 'The medicines trolley must be kept locked at all times and when not in use, secured to the wall or in a locked room'. On one occasion, the medicines trolley was left, locked but unattended in an unlocked room. We informed the Clinical Lead and the registered nurse of our findings.

Although the provider's policy stated that full and accurate records of medicine administration should be maintained, we saw there were gaps within the medicine administration record (MAR) charts. Where there were gaps, the meds were gone from the packs, indicating they probably had been administered. We were told that staff had been told to double check at the end of the meds round to be sure they had signed everything, and we did observe the agency nurse doing this on day one. Nurses said if they noticed gaps from a previous shift, they would inform the clinical lead. Topical medicines were administered by support workers. All of the topical medicine charts had been fully completed and were up to date.

Medicines were not always available. On one occasion the nurse could not administer a person's medicine as prescribed because the last tablet had been administered the previous day and new stock had not been ordered or arrived. We spoke with the nurse who said they would order some when they had finished administering the medicines

Medicines requiring refrigeration were stored in a fridge within the clinical room, but it was not a designated medicines fridge. The temperature was not monitored and there were no records to show it had been monitored. This meant there was a risk of medicines being stored at an incorrect temperature.

This was a breach of regulation 12 (g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed part of the medicine round on both days of the inspection. On both days, nurses who administered medicines wore red "do not disturb" tabards. These help to advise people using the service, staff and visitors that the nurse should not be interrupted whilst the medicines are being administered. This helps to reduce the risk of medicine errors. Both nurses were knowledgeable about people's medicines and knew why people had been prescribed them. They took their time and didn't rush people. They ensured people had drinks available and checked they had swallowed their medicines before signing the medicines administration record. We saw

Is the service safe?

people being asked if they required pain relief, and when one person was unable to clearly communicate if they were in pain, the nurse assessed the person and used their clinical judgement appropriately to ensure the person was pain free.

Assessments were undertaken to identify risks to people who used the service. Moving and handling assessments had been completed for people and we observed some people being hoisted into armchairs in accordance with the guidance within their plans. However, some of the information within the care plans was not clear. For example, in one person's plan, the moving and handling guidance stated two staff should use a hoist and sling to transfer them safely. When the plan had been reviewed, staff had documented it was safer with three staff so that one could hold the person's hands and reassure them. The latest review did not make it clear if staff should ensure two or three people assisted with any transfers. This meant the guidance for staff was not clear on how many staff were needed to support this person.

When walking round the building we noted various areas were cluttered with equipment and furniture. For example we saw in one bathroom there was an armchair, table and picture stored in there. This bathroom was equipped with a walk in shower. When we asked staff if people would use this shower they replied "Of course. It's their choice, if they wish to use it they can." We asked why the furniture was in the bathroom but they did not know. They explained before any person could use the bathroom they would have to "Clear it out". We observed hoists being stored in another bathroom making it inaccessible. For people who were mobile these areas were unsafe as people could easily trip over or fall against the equipment and furniture.

These concerns were a breach of regulation 12 (b)(d) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People receiving a service were not always protected by safe recruitment and selection processes. All staff were subject to a formal interview. Records we looked at confirmed this. We looked at six staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. However two records showed that where there were gaps in people's employment history the reasons for this had not been clarified with the person. We saw the interview questions checklist for one person which had not been adequately filled in. For each question there was a tick but no record of the person's skills and abilities in this area or if they required any further development as required by the form.

Staff were subject to a Disclosure and Barring Service (DBS) check before they started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

People and their relatives told us they or their relative felt safe and supported living at Ravenscroft. Comments included "I feel confident with the care he receives as they know him well. I feel he is safe here" and "Staff tell me what they are doing which makes me feel safe."

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse. They felt confident with reporting any concerns they may have and that appropriate action would be taken by the management team. Any concerns about the safety or welfare of a person were reported to the interim manager or clinical lead who investigated the concerns and reported them to the local authority safeguarding team as required

Requires Improvement

Is the service effective?

Our findings

Staff were aware of their roles and responsibilities. However regular meetings were not held between staff and their line manager to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. When we spoke with staff there were mixed views on how easy it was for them to access training and support. One staff member said "I know what my training needs are, but we haven't had a manager long enough for me to speak to anyone about it" and "No idea when I last had a supervision or an appraisal." Staff said they felt supported by the interim manager who had held team meetings to discuss issues. Staff said these meetings had made them feel listened to.

Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. However induction information was missing from three of the personnel files we reviewed. This meant it was unclear what induction staff had completed and if they had been signed off as being competent.

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

We spoke with the project manager who explained staff needed to have completed safeguarding of vulnerable adults and moving of handling people training before starting in their role. One member of staff who was relatively new in post (two months) said they hadn't attended moving and handling training yet. They had been told not to hoist anybody but they were allowed to assist other staff. The provider's moving and handling policy stated that 'Staff to receive mandatory manual handling instruction and training within their induction period'. The staff member felt confident enough not to participate in moving a person without having completed the training.

Staff told us they received the core training required by the provider, such as safeguarding, infection control, manual handling and health and safety. Whilst most people's training was up to date the interim manager had reviewed records to identify those staff whose training had expired and had plans in place to address training requirements.

People told us they believed the staff who cared and supported them had the right skills to do so. Comments included "The staff are very good. When they are hoisting me they always tell me what they are doing" and "The staff are very genuine. They have taken the time to get to know him."

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so.

During the inspection, the clinical lead told us they were in the process of making applications for DoLS authorisations. Applications had been submitted by the provider to the local authority.

However the requirements of the Mental Capacity Act were not always followed by the provider when assessing people's capacity to make decisions. We looked at ten people's care records and found records of assessments of capacity were not appropriately completed. For example where people required support with personal care or moving and handling they were deemed to lack capacity. The assessments focused on someone's need for support rather than their ability to make decisions. The assessments did not contain any evidence of the processes gone through to check people's capacity and how conclusions around people's capacity to make decisions had been made. Where people were deemed to lack capacity there were no best interests decision in place.

We reviewed people's DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) and found that these had not been completed correctly. One person's DNACPR, identified that they had capacity to consent. However there was no evidence that the person had been involved in making this decision and the form noted that the GP had discussed this with the person's relative only. There was no evidence that any discussions had taken place with the person about their end of life wishes by the provider.

Requires Improvement

Is the service effective?

Another person's capacity assessment stated they had a DNACPR in place but this could not be found in their care plan. We have asked the provider to take immediate action to review people's DNACPR

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Through conversation staff demonstrated they understood the principles of the Mental Capacity Act. Staff told us how they supported people to be involved in making daily choices such as what time people wanted to get up, what they would like to eat at meal times and activities they wanted to take part in, or not take part in.

Records did not clearly identify if people were being supported to receive sufficient to eat and drink. During our inspection we observed people had access to food and drink throughout the day and staff supported them when required. People who had been identified as being at risk of poor nutrition or hydration were having their intake monitored with the use of food and fluid charts. However, the quality of documentation was poor and inconsistent which meant it was difficult for staff to assess if the person had eaten or drunk enough. For example, the fluid input charts should have been totalled at the end of each day so staff could monitor the input throughout the 24 hour period. We looked at one person's chart and there were no total inputs recorded for 4 days in September. Another person's chart stated they had drunk 200 mls of fluid at 08.20 that morning. We looked at the chart at 12.30 and there were no other recordings noted which indicated the person had only had one drink so far that day. This chart also had total input recordings missing for 5 days during September. The lack of detail and the lack of recordings meant there was a risk people may not have sufficient to eat and drink and that staff would not be able to assess this risk or escalate concerns swiftly.

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

People ate breakfast in their rooms and the majority of people ate their lunch in the communal dining room. One person told us "I had my usual porridge for breakfast, it was very nice" and "I always have breakfast in bed." People were not rushed and were able to take their time over their meals. People told us the food was "Nice" and "It's always warm". One relative said "I know the food is good because I've eaten here and there's plenty of it". One person using the service told us they were vegetarian. They said "I always get a couple of choices, and if I don't fancy either, they will make me something else. The food is very good".

We spoke with the chef who told us they were given information about people's dietary needs by the care staff and nurses and they had information in the kitchen about particular likes and dislikes. They explained that people had a choice of meals. They said if people did not like what was on the menu then they were able to request alternatives. The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance.

People were supported to maintain good health and access healthcare services. Care plans showed where people had nutritional needs and the actions taken by staff. For example, one person had lost weight which staff had highlighted as a concern. GP advice had been sought and food supplements were being provided. The person was being weighed weekly and had gained weight since starting the supplements.

Care plans contained notes from GP's or other healthcare professionals' visits. For example, we saw records of visits from tissue viability nurses and chiropodists. The majority of people and visitors we spoke with said they felt they had access to healthcare services when needed. One relative told us they felt the home met their family members health needs. They said "They are quick to get the GP involved and always keep me up to date." One person using the service told us "They are very good. If I'm not feeling well they will call the GP and get me to hospital if needed." One person using the service said "I've got some sores in my mouth that won't go." We heard the clinical lead speaking with the person about this and telling the person they would contact the dentist that day. A relative of another person said "I have picked up when my relative has got wheezy before and I have had to ask staff to get the GP in."

Good

Is the service caring?

Our findings

People and relatives spoke positively regarding the care and support they or their relative received. Comments included “My relative has been here for a few months now and the staff are brilliant, so caring”, I can’t fault it the staff are really good” and “The staff are very kind here, I can’t fault their kindness. It’s like a home from home.” One relative said “X always looks clean and smart; they go to the hairdresser and have their nails done”. Another said “The laundry team are amazing, we’ve never lost anything nor had anything damaged”.

People were treated with kindness and compassion by staff. All of the staff we spoke with said they wanted to provide good care to people. They said “Staff have the time here to help people, nobody is rushed”, “The staff here do really care about the residents” and care here is really good, we don’t leave people in bed.”

We found staff were knowledgeable about people’s individual care and support needs. They were able to describe people as individuals. Staff knew about people’s likes, dislikes and preferences. One staff member told us “We are very person centred here. It’s all about people’s choices and things are done with people as individuals.” Another member of staff said “We have a good rapport with residents, we know them well.”

People’s privacy and dignity was maintained. Personal care was delivered behind closed doors and staff hung signs on doors to indicate they were not to be disturbed. One member of staff said “I always pull the curtains, make sure the door is shut, and keep people covered when I’m helping them get washed and dressed”. Another member of staff explained how one person liked them to sing when they were receiving personal care. They said “Personal care can be invasive so I sing along to make it relaxing for the person.”

One person explained that when they were receiving personal care staff always made sure they were covered. They said “I now feel safe when I’m being hoisted. Staff tell me what they are doing and make sure I’m covered up.”

We observed lunchtime on one day of our visit. Staff checked people had enough to eat and asked people if they wanted any more when they had finished. We observed one person who had finished their lunch being offered a second helping. Those people who required staff assistance to eat were supported in a sensitive manner. Staff sat down with people and gave them time to eat the meal at their pace. One person did not want to eat either of the menu choices. Staff asked if they would like a sandwich. We saw staff trying to encourage the person to eat and then respecting their choice not to eat. We saw a little later that this person had been given a fortified drink and had a plate of snacks in front of them so they could eat at their leisure.

In the afternoon we observed people taking part in a music session. People and staff shared jokes and we saw some people laughing and singing along to familiar songs. People had bells in front of them to join in with the music and a staff member pressed one person’s bell as they went past which caused the person to laugh with the staff member. People smiled when approached by staff and held out their hands to join in with a song and dance. This indicated that people felt comfortable with staff.

We saw most staff, when talking with people, got down to their level if they were in a chair or wheelchair. We saw one staff member kneel down to offer a person reassurance about joining in the music session. They afforded the person time to talk and reassured them they could go back to their room at any time they stopped enjoying the music session.

One person who had recently fallen was offered reassurance by staff regarding the sling they needed to wear. Staff explained to the person why the sling was needed and how long they needed to wear it for. They also offered the person some pain relief if they felt they needed it. They supported the person to then walk to the music session which calmed and distracted them.

We noted on one occasion a staff member entering the communal lounge and said “Right I am going to put the TV on now for a change.” They turned off the music and put on the television without asking people if this was what they wanted. On another occasion a person was supported to sit in the communal lounge after receiving personal care. Whilst the staff member asked if they wanted the television on, they did not ask what programme the person wanted to watch. When we spoke to the clinical lead and the interim manager regarding this they said they would be addressing this through training. They explained that they were organising 'experiential' training so that staff could experience what it is like to be receiving care.

Good

Is the service caring?

Visitors were unrestricted and we saw many people come to visit their relatives during the inspection. One relative told us “I come and visit when I like. I can also have my lunch here which is very nice.”

Requires Improvement

Is the service responsive?

Our findings

During our inspection we looked at ten people's care and support plans and found they were not always up to date and did not always reflect the needs of people. For example, in one person's plan staff had documented the person knew how to use the call bell and could ring for assistance. However, when we went to the person's room, they did not have a call bell and we had to ask staff to provide one. This person's health had been deteriorating and they required regular pain relief. The nurse on duty administering the medicines had assessed the person's pain and had administered some analgesia in accordance with the MAR chart, which stated "PRN" (as required). The care plan stated the person should receive the analgesia four times a day, but this did not reflect the MAR chart instructions or the staff signatures indicating when analgesia had been provided.

Another plan did not contain enough information for staff to gain a full understanding of the person's needs. For example, the person was diabetic and the plan stated they had unstable blood sugar levels. Whilst nursing staff monitored the blood sugars, but there was no guidance for staff on how to identify the signs of hypo or hyperglycaemia.

One person's care plan documented that they were able to 'Self toilet'. The plan stated the person used a Zimmer frame to support their mobility. We observed this person being supported into the communal lounge using a wheelchair. They used a Zimmer frame to stand and transfer into an armchair and the Zimmer frame was then removed. When we asked a staff member about this they explained that the person wasn't currently walking due to health issues. We asked how this person would be able to access the bathroom or call for assistance as they didn't have a call bell. The staff member explained staff passed through the lounge frequently to check on people. We sat in the lounge for an hour with no staff attending during this time.

We found some of the wording used within the care plans was not person centred. For example one plan stated 'X starts wandering from 4.30pm to 5pm and wanders until the night staff take them to bed' and 'Dislikes having to be taken to the toilet every hour due to family's insistence'.

Care plans were reviewed monthly. However the plans were not updated to reflect changes. For example one person's care plan stated they were able to stand and transfer with one staff member. However when we spoke with staff they confirmed the person was unable to do this. A review in August noted the person now required the use of a hoist to transfer and for two staff to be present. The care plan had not been updated to reflect this. There was also no guidance for staff to following on how the person should be hoisted.

Daily records to monitor people's well-being were not always completed. For example one person had a food and fluid chart in place. There were gaps in recording where no food had been recorded. It was also not recorded if the person had refused food and that was the reason there was no food recorded. Other recording noted the person had eaten all their lunch but did not say what it was they had eaten.

There were personal hygiene records in place for people, but these were not always up to date. For example, according to one person's record, they had not been washed on the 8th and 9th of September. Another person's plan stated they should be taken to the toilet hourly, but according to the chart in place, this did not happen. There were significant gaps and it was not clear if staff had omitted to take them to the toilet or if the person had declined to be taken. The chart did not reflect the guidance within the person's care plan.

One person's care plan directed staff to apply a daily barrier cream. The last recording of this being applied was five days prior to our inspection.

There was some evidence of family involvement in the care planning process but this was limited. One plan we looked at contained a life history document completed by a relative, but this was not present in all of the plans we saw.

This was a breach of Regulation 9 (1)(b)(c) (3)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a care needs summary in place for all people which included details of the person's preferred routine, support required and likes and dislikes. These provided a good amount of detail for staff to gain an overview of how to care for the person. Where people had wound care plans in place, there were photographs in place to monitor progress or deterioration. Where support and advice had

Requires Improvement

Is the service responsive?

been sought from specialists such as the Tissue Viability nurse, this was documented. The plans contained step by step detail for staff on how the wound should be dressed and the frequency.

The home had two activity co-ordinators who organised group activities throughout the week. They also offered people activities on an individual basis when they could. Activities included music, exercise, games and arts and crafts. They also invited outside entertainment to come in to the home to perform. The activities co-ordinator told us it was people's choice if they wished to join in. One person told us "I enjoy joining in the activities, it's fun."

There was a procedure in place which outlined how the provider would respond to complaints. People and their relatives told us they knew what to do to make a complaint if they were unhappy with any aspects of care they were receiving. Two relatives said they had attended a meeting with the interim manager recently. Both said they knew how to complain if they needed to. One said "I come a couple of times a week so that I can keep an eye on things, but I'm happy to speak up if I need to". However we reviewed a recent complaint that had been made in April 2015 by a relative about their family member's care and support. Whilst we could see a comprehensive investigation had taken place there were no records of contact with the complainant or if they were satisfied with the investigation. The clinical lead said she would follow this up.

Inadequate

Is the service well-led?

Our findings

Whilst there was a registered manager employed by the service, they were currently on long term leave. The home was being overseen by an interim manager and the clinical nursing lead.

Whilst the provider had quality assurance and audit process in place these were not effective. We reviewed quality monitoring reports that had been completed by the provider's compliance officer. These covered the five domains as identified by the Care Quality Commission (CQC) and included areas such as infection control, care plans, staffing, the safe management of medicines and premises safety. The audit had a traffic light colour coded system to identify when things required action. Where required actions had been identified the reports submitted showed green, which to senior management indicated no action was required. For example information in care plans had been identified as needing to be updated. This had been marked as green. This meant an action plan was not completed by the registered manager to address the areas of concern.This had also not been identified by senior management as part of their quality assurance processes.

However the interim manager had identified that these audits did not reflect the actions needed and had completed an initial action plan to address the issues we have identified during our inspection.

There was a clear procedure for recording incidents and accidents. Any accidents or incidents relating to people were documented and actions taken were recorded. Records showed these had not been reviewed since May 2015.

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

People and their family were involved with the service and their feedback was sought by the provider and the registered manager. The interim manager had recently held a relative and resident meeting in August 2015. During this meeting updates were provided and people were invited to make suggestions about how the service could be improved.

Staff were motivated and caring. Staff were positive about the support the received from the interim manager. Staff told us "We are like a big family here, we are very supportive of each other", "The residents are our priority" and "It's lovely working here. We've had some really positive feedback from families about the care we provide." Staff were aware of the organisations visions and values. They told us their role was to support people to be as independent as possible. One staff member told us "It's all about what they (residents) want. It's important they are stimulated and are a part of the home life."

Staff did also say that due to changes within the service morale was "low" and "poor" as they didn't know what was happening with the service long term. Whilst staff had not received regular supervision they told us the interim manager had been holding team meetings to keep everyone up to date but to also provide them with an opportunity to raise any concerns or make suggestions on how to develop the service. They said the interim manager and clinical lead were working hard to improve the service. Staff felt listened to and felt any concerns they raised would be acted on.

Staff all understood the provider's whistleblowing policy and procedure and would feel confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One member of staff told us "I would not hesitate to report any concerns I had about staff's working practices. The management here are fantastic with staff and residents."

The service had appropriate arrangements in place for managing emergencies. There was a contingency plan which contained information about what to do should an unexpected event occur, for example a fire. There were personal evacuation plans in place in people's care plans. This meant staff had guidance on how to support people from the building safely in the event of a fire. There were arrangements in place for staff to contact management out of hours should they require support.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected by the prevention and control of infection. (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that the premises and equipment were clean and maintained to a standard appropriate for the purposes for which they were being used. (1)(a)(e) (2)

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 provider did not ensure medicines were managed or stored safely. (g)

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 provider did not ensure that appropriate assessments were completed to reduce the risks of health and safety for people using the service. They also did not ensure that the premises were safe for the people living there. (2)(a)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate training, supervision and appraisal as is necessary. (2)(a)**

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 **Capacity assessments were not appropriately completed for those people deemed to lack capacity to make decisions.**

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 **Records did not clearly identify if people were being supported to receive sufficient to eat and drink. (2)(c)**

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 provider did not always ensure people's care and support plans were up to date and reflected the needs of people. (1)(b)(c) (3)(d)(f)**

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 **Whilst the provider had quality assurance and audit process in place these were not effective. (1) (2)(a)**

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected by the prevention and control of infection. (h)

The enforcement action we took:
As this was a breach we issued a warning notice to the registered provider. We have set a timescale of 28 days by which the provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure that the premises and equipment were clean and maintained to a standard appropriate for the purposes for which they were being used. (1)(a)(e) (2)

The enforcement action we took:
As this was a breach we issued a warning notice to the registered provider. We have set a timescale of 28 days by which the provider must address this breach.