

Ackworth House Limited

Ackworth House Nursing Home

Inspection report

The Beach
Filey
North Yorkshire
YO14 9LA

Tel: 01723 515888

Website: www.ackworth-house.co.uk

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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?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Inadequate



Overall summary

We carried out an unannounced comprehensive inspection of this service on 19 August 2014. Breaches of legal requirements were found. As a result we undertook a focused inspection on 5 February 2015 to follow up on whether action had been taken to deal with the breaches. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 19 August 2014

The inspection took place on 19th August 2014 and was unannounced. At our inspection in September 2013 and again in January 2014 we had identified breaches of regulations relating to care and welfare, the management of medicines, staffing levels and meeting nutritional needs. Following this the provider sent us an action plan telling us about the improvements they intended to make. During this inspection we looked at whether or not

Summary of findings

those improvements had been made. We found that improvements still needed to be made in regard to management of medicines, care and welfare and staffing levels. We also found additional areas of concern in relation to the environment, quality assurance and completion of records. At the last inspection on 18 January 2014 we asked the provider to take action to make improvements in relation to meeting nutritional needs and we found this action had been completed.

Ackworth House is a care home providing nursing for up to 43 older people with a physical or sensory impairment. The main building is a converted hotel with four floors. At the rear of the home there is a newer extension over two floors. The home is situated along the beach front in the small seaside town of Filey. At the time of our visit there were 29 people living at the service. The acting manager, who was also a director of the company which owned this service, had been in post since the previous manager left the service in December 2013. They had applied to become registered but had not been successful in their application. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. They continue to act as manager until a suitable person is employed to be the registered manager.

Although people told us they felt safe we found that this service was not providing consistently safe care. We found staffing levels appeared good but there was a high proportion of agency staff and account had not been taken of people's needs and other factors when deciding on staffing levels which meant people's safety was compromised. We found people's care plans did not always reflect their care needs and risk assessments were not always in place. There were areas within the service which were odorous and dirty. We found the service did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Some people at the service were not able to tell us if their freedom was restricted but we could see that there were no recorded decisions about why, for instance, those people did not go out in the fresh air. The MCA and DoLS require providers to submit applications to

a 'Supervisory Body' for authority to restrict people's liberty. It was clear from paperwork we inspected that this had not been done and that staff did not fully understand the requirements or principles of the MCA.

Medicines were not always managed safely for people. There were discrepancies in numbers of tablets available and number of tablets given. Medicines were in use that were out of date and were not always stored safely.

The service was not effective. People we spoke with told us that they felt well cared for but one relative expressed concern about staff skills and knowledge. Staff had received an induction when they began working for the service but supervision was not up to date. There were gaps in staff training. People identified health needs were not always met and some people did not have risk assessments in place which meant that staff had not always identified when people needed additional support. Nutritional needs were met but we saw people had varied experiences at mealtimes. Some relatives told us they felt that people living at the home did not receive the support they required to eat and drink. There had been no adaptations made to the environment to help people maintain their independence..

People had a mixed experience with staff. They told us that some staff were kind but some focussed on tasks rather than the person. People were not always involved in planning their own care. There were no activities seen to be taking place although we were told that some were planned. People using the service told us there were no regular activities.

There was no registered manager at this service and there was no consistent leadership.

Focused Inspection of 5 February 2015

After our inspection of 19 August 2014 the provider, that is, the legal entity that provides a regulated adult social care or healthcare service to members of the public, wrote to us to say what they would do to meet legal requirements in relation to breaches of regulations identified with a completion date of 31 January 2015. The breaches were of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services, Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers, Regulation 12 HSCA 2008

Summary of findings

(Regulated Activities) Regulations 2010 Cleanliness and infection control, Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines, Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises, Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records and Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing .

We undertook a focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. We found that while some improvements had been in some areas, concerns remained in others.

We found that the service was not safe. This was because medicines were still not managed safely. One person had been identified at the comprehensive inspection of 19 August 2014 as having their medication administered covertly with no records in place to support the decision to do so. Covert administration is when medicines are given in food or drink to people unable to give their consent or refuse treatment. The medication was still administered covertly when we carried out the focused inspection of 5 February 2015 and when we examined medicine administration records and care plans we found that staff had not reviewed the records and had not documented the decision or any best interest decision making in line with the principles of the Mental Capacity Act 2005. A safeguarding alert was made to the local authority about this.

Other areas had improved. The manager showed us records of the assessment tool they had used to determine what staffing levels were needed to meet people's needs. The staffing level on the day of our visit

were sufficient and rotas confirmed that these levels were consistent. A programme of training had started and staff were able to tell us about the training they had completed which was relevant to the needs of people who used the service. This meant that people were protected because there were sufficient staff on duty with the appropriate knowledge and skills to meet their needs.

Action had been taken to improve the effectiveness of the service. We observed people who used the service receiving support during mealtimes. Staff spent time with people and the mealtime was unhurried and calm. People were given the support they needed to ensure they were able to eat and drink

We saw that work had started to improve the environment. There was appropriate signage throughout the building. In the dining room there were menus displayed with pictures of the food to be offered which helped those people living with dementia to make a choice about what they would like to eat. There was also a memory board displaying the day, date, and season with words and pictures helping to orientate people. The provider told us that further improvements were being planned.

People who used the service told us that they found the staff kind and caring. They told us that there had been improvements in the attitude of some staff since the last inspection and the addition of a nurse manager and experienced nurses to the team was helping to improve the management and leadership of the service. There was now a manager employed at the service who had applied to the Care Quality Commission to become registered.

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?

19 August 2014

The service was not safe. Although people told us they felt safe we found this service was not providing consistently safe care. We found staffing levels appeared good but there were a high proportion of agency staff and account had not been taken of people's needs and other factors when deciding on staffing levels which meant people's safety was compromised.

We found people's care plans did not always reflect their care needs and risk assessments were not always in place.

We found the service did not meet the requirements of the Deprivation of Liberty Safeguards (DoLS). Some people at the service were not able to tell us if their freedoms were restricted but we could see that they did not have clearly recorded best interest decisions in their care files. This meant that in order to protect the rights of people who had limited capacity to make their own decisions applications should have been made to a supervisory body.

Medicines were not always managed safely for people and records had not been completed correctly.

There were areas within the service which were odorous and dirty.

5 February 2015

The service was not safe. We found that medicines were not managed safely and records not completed correctly.

Staff had started to update and improve care plans but we saw examples where risks had not being identified and there was no clear plan and risk assessment to ensure that staff understood the needs of the person.

We found that staffing levels had improved at this visit because the provider was using a tool to determine what staff were needed according to peoples needs.

Staff at the service were using cleaning schedules and audits which ensured the cleanliness of the building and equipment because they were being checked regularly.

Inadequate



Is the service effective?

19 August 2014

The service was not effective. People we spoke with told us that they felt well cared for but one relative expressed concern about staff skills and knowledge. Staff had received an induction when they began working for the service but supervision was not up to date.

Requires Improvement



Summary of findings

Peoples identified health needs were met and staff contacted healthcare professionals if they needed additional support. Some people 's care plans did not have risks identified.

People's nutritional needs were met but they did have varied mealtime experiences. Some people felt that their relative did not receive the support they required.

The environment was not suitable for people living with a dementia or for those who wished to maintain their independence. There were no adaptations such as signage or coloured handrails. There was nowhere that a person could make a drink themselves.

5 February 2015

The service was not effective. Although there had been action taken to improve the effectiveness of the service some people's care plans did not have risks identified.

Mealtimes were calm and people received the support they needed.

There were improvements to the environment with the addition of appropriate signage and pictures. However, some areas for change identified in the infection control audit had not yet being carried out.

Is the service caring?

19 August 2014

The service was not caring.

People told us that most staff were kind to them but some had a different experience.

Staff appeared task focussed although we did observe some staff had a good rapport with people.

People were not always involved in planning their own care and we found people receiving end of life care did not have the appropriate paperwork in place which meant that staff had not taken account of their wishes.

5 February 2015

People who used the service told us that there had been improvements and that staff were kind and caring towards them.

However one person told us that they had to wait a significant length of time for assistance. There was on-going auditing of call bell tests which were carried out randomly and the manager was using staff meetings as a forum to discuss this issue and present training about dignity.

Staff were now in sufficient numbers which gave them the time to be more person centred spending more time with people.

Requires Improvement



Summary of findings

Is the service responsive?

19 August 2014

The service was not responsive We did not find this service responded to people's care needs promptly and we heard one person's call bell ring for fifteen minutes. This meant people's needs were not attended to in a timely way and their dignity could have been compromised.

Reviews were not regularly carried out by the staff and most people had not been involved in any review of their care.

Complaints had been logged and responded to in line with the service policy and procedure but there was no evidence of learning from complaints.

We observed no activities taking place and although we could see some activities advertised they were infrequent. People told us that there were very few activities organised which meant that there was a risk of social isolation for some people.

5 February 2015

Staff did not always respond to people's needs in a timely manner.

Reviews were not being carried out for everyone and care plans had not always been updated for everyone.

Activities were now taking place regularly with a programme in place. Volunteers now assisted with activities and all staff were encouraged to get involved. People were observed doing activities which they clearly enjoyed.

Requires Improvement



Is the service well-led?

19 August 2014

This service was not well led. There was no registered manager at this service.

People told us that they felt the leadership of the service could be improved.

Care provided to people was not always guided by best practice

5 February 2015

A manager had been employed by the service and had applied to be registered by the Care Quality Commission.

People told us at this inspection that the leadership within the service had improved. The provider had taken steps to employ a manager and two nurses who had experience of working in this type of service.

Quality assurance was not always effective but we saw that steps were being taken to improve using best practice guidance and the expertise of other professionals outside the organisation.

Inadequate



Ackworth House Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Ackworth House Nursing Home.

We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first, a comprehensive inspection of all aspects of the service, was undertaken on 19 August 2014.

This inspection identified breaches of regulations. The second was made on 5 February 2015, and focused on following up on action taken in relation to the breaches of legal requirements we found on 19 August 2014. You can find full information about our findings in the detailed findings sections of this report.'

Comprehensive Inspection

We inspected the home on 19 August 2014. We looked at all areas of the service including people's bedrooms with their permission, we looked at care records and associated risk assessments for seven people, we observed medication being administered and inspected 12 medicine administration records (MAR). We observed a lunchtime period in the dining room and observed people being helped with their meals in their bedrooms. We used the Short Observational Framework for Inspection (SOFI) because there were seven people living at the home who were living with a dementia. SOFI is a specific way of observing care to help us understand the experience of

people who could not talk with us. During the course of our inspection we spoke with seven people who lived at the service, seven relatives, six staff, the clinical lead nurse, the two directors and two health care professionals who visited people on the day of our inspection.

The inspection team consisted of an adult social care inspector, a pharmacy inspector, a specialist professional advisor, whose specialism was in occupational therapy, and an expert by experience who had experience of palliative and end of life care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed all the information we held about the service. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the local authority about this service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Detailed findings

Focused Inspection

We undertook an unannounced focused inspection of Ackworth House Nursing Home on 5 February 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection had been made. The team inspected the service against all of the five questions we ask about services: is the service safe, effective, caring, responsive and well led? This is because the service was not meeting some relevant legal requirements.

The inspection was undertaken by an adult social care inspector, a pharmacy inspector and an expert by experience, all of whom had attended the inspection carried out on 19 August 2014. We looked at all areas of the service, observed breakfast and lunchtime periods in the dining room and looked in the rooms of people who used the service with their permission. We observed a staff handover and inspected eleven medication records. We case tracked care plans, risk assessments and charts of four people who used the service and spoke to nine people.

We also spoke with the directors, the manager, two nursing staff, two care staff, two kitchen staff, a laundry person, an

activities co-ordinator and a volunteer who assisted with activities. We used the Short Observational Framework for Inspection (SOFI) because there were five people identified by staff as living with dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed staff training and supervision records, policies and procedures, service and maintenance records relating to equipment and services and quality assurance documentation completed at the service.

Before the inspection we had attended or received minutes of meetings arranged by the local authority and attended by representatives of the Scarborough and Ryedale Clinical Commissioning Group (CCG) as well as the directors of this service in order to monitor the situation at Ackworth House Nursing Home. We had also sought updates from the local authority adult social care team about the welfare of people at this service. As part of this inspection we considered the information that had been shared with us by the local authority and the CCG, looked at safeguarding alerts that had been made and any other information we held about this service.

Is the service safe?

Our findings

Findings from the comprehensive inspection of 19 August 2014

This service was not safe. When we inspected this service in September 2013 we found people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage people's medicines. At this visit we saw that although people told us they felt safe, there were no improvements and the same issues highlighted in September 2013 were repeated. There had been five medication errors at the service over the last twelve months which related to people not receiving medication in a timely manner, returns of medication and roles and responsibilities of staff. This showed that the service was not learning from previous errors and making improvements to the management of medicines putting people at risk of harm.

The records which confirmed the administration of medication or application of creams and other topical preparations were incomplete. Incomplete record keeping means we were not able to confirm that these medicines were being used as prescribed.

When we checked a sample of 'boxed' medicines for six people alongside the records we found most did not match up so we could not be sure if people were having their medication administered correctly. For instance one person prescribed medication for epilepsy should have been given four tablets over the course of twenty four hours. There were 112 tablets received into the home, 52 tablets recorded as given on the medicine administration record (MAR) so there should have been 50 tablets left. There were 52 left and no explanation had been given for this on the MAR. This meant that this person may have missed two of their tablets which could have had an adverse effect on their health.

People were not protected against the risks associated with covert administration of medication. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. When one person had medicines administered crushed and mixed with food no records were available to show how the decision to

administer this medication in this way had been reached. No guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way.

Medicine for another person was crushed and administered in another liquid medicine even though the risk assessment said that medicines should not be mixed. Care staff could not confirm that this medicine was safe to administer in this form.

We looked at the guidance available about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that staff did not have enough information about what medicines were prescribed for and how to safely administer them.

Records were kept of room temperature and fridge temperature in the treatment room, however there were gaps in these records. On the day of our visit the temperature was 9.5 degrees centigrade, and on three other recorded occasions the fridge temperature was over 8 degrees centigrade which was higher than recommended for the storage of medicines. This meant there was a risk that medicines may be stored above the temperature recommended by the manufacturer and may not have been safe to use.

We saw that three ampoules for one person, with a short shelf life once opened, were still being used past the recommended date of expiry. This meant that staff could not be sure this medicine was safe to administer. We asked staff to dispose of these immediately.

We found the controlled drugs, which are medicines which may be liable to misuse, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We found that the service's arrangements for the management of medicines did not protect people. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous visit we had found staffing levels were not planned in line with the needs of people who lived at the service. At this inspection we found there had not been improvements.

Is the service safe?

The provider was unable to demonstrate that a needs analysis or risk assessment had been carried out to determine the staffing needs for this service on any given day. When asked about how they responded to absence they said, "It is usually sickness and we can't get cover". During our visit the provider was trying to cover a shift for the following day and when we left during the evening they had still not covered the shift. The provider told us that one person would cover despite them having told us that they had worked in excess of 60 hours and the next day should have been their rest day. We checked this person's staff file and there was no agreement signed by the member of staff to work over the prescribed limit described in Working Times Regulations. This meant that staff were not working in accordance with working times legislation.

On the day we visited there was one nurse on duty and seven care staff. In addition there was a chef, a kitchen assistant, a person working in the laundry, a person who gave out drinks and helped when people needed support to eat and drink and two cleaning staff. The staff numbers appeared to be sufficient but the complexity of different people's conditions and the layout of the building combined together meant that staff struggled to meet people's needs effectively. Three of the staff were from an agency and only one of them had worked at this service regularly. It was necessary for more experienced staff to supervise the agency staff. In addition a person was admitted to the service during the day which exacerbated the problem. All of these factors meant that the safety of people who lived at the service was compromised.

During the inspection the team could not find staff to speak to them and were not visible in the communal rooms throughout the day. An example of this was when we heard a person call out from a lounge on the ground floor in the evening. We went to look for a member of staff and there were no staff on the ground floor. No one came back to that floor until the owner walked into the building and we asked them to arrange for someone to check on this person. There was no means of calling for assistance which would alert staff in different parts of the building from the ground floor. This meant that people were left with no support for long periods.

Every person spoken with said there weren't enough staff. People told us, "There are never enough, and they don't

stay." "There can't be enough staff when you think how long you have to wait when you ring the bell", "You have to be patient, they're run off their feet", "I wouldn't recommend it; there aren't enough staff."

One member of staff told us, "It has happened a few times that there is only one nurse and three carers on duty". When we spoke with the provider they told us that they always aimed to have two nurses and seven staff on duty and that the staff levels on the day of inspection were correct. When we checked the staff rotas we could see there were variations in staffing levels particularly on a weekend. We could see there had been occasions when there were three or four care staff although sometimes there were five and the rotas showed that there was one nurse on duty for each shift. This meant that people were not being safeguarded because they were not always supported by the number of staff described by the provider as "normal staffing levels".

We found that the arrangements for staffing did not safeguard people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

During our inspection we saw that people were left in their chairs for long periods with no position change. When we checked one person's care plan it said this person should have had regular positional changes in addition to having pressure relieving aids in place. We did not see any staff assist them between 9.15am and 1pm at which point we left the area they were sitting in. We did see that they were sat on a pressure relieving cushion.

When we spoke with staff about this they told us the person was "having their hair done" but we had seen this had been done early in the morning. We spoke to the person's relative and they said, "(relative) is sat in her wheelchair for long periods". A different staff member told us, "We normally put them in a comfy chair but it's not done today because we are too busy". This meant that people in wheelchairs who were left for long periods were at risk of pressure damage. We have made a safeguarding alert to the local authority about this person.

We saw people were not always supported according to their needs by staff and that care plans did not reflect those needs. For instance we saw a person who was nursed in bed and had no clothing on. There was no call bell close by and according to the fluid chart they had received no oral

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liquids between 5pm the previous evening to 9am on the day of our inspection. Some changes had been made by the GP to the level of fluid they should receive but when we checked the care plan it had not been updated with any changes. We have made a safeguarding alert to the local authority about this person.

There had been a recent incident at the service when one person was asked to go to bed by a member of staff. When they said they did not want to they were told, "If you don't go to bed now I won't be back. I don't have time for this." This was reported and investigated by the local authority. We spoke with the service user who said things had improved recently but they believed that was because of the visits by local authority staff

The provider completed their provider information return (PIR) and told us they had made no Deprivation of Liberty safeguards (DoLS) applications to the local authority. In March 2014 a supreme court judgement made it clear that if a person lacking capacity to consent to arrangements for their care, is subject to continuous supervision and control and is not free to leave the service they are likely to be deprived of their liberty. We were told that seven people with a dementia lived at Ackworth House Nursing Home who were not able to leave without assistance. This meant that the provider was not protecting the rights of service users by arranging for an assessment to be carried out which would test whether or not those people were being deprived of their liberty and whether or not that was done so lawfully.

We saw that some service users were unable to consent to care and treatment and had a mental capacity assessment completed but it was not always clear what decision was being tested. The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a persons best interests. In one person's file the decision under question was 'New assessments process' and the outcome was that the individual lacked capacity to consent to 'Long term or to do with well-being and care'. This meant that decisions required were not clear and questions were not clearly written or records completed properly. This told us staff

were not working within the principles of the MCA by doing everything to empower service users to make as many decisions for themselves as they could and recording those decisions.

We found that records were not completed accurately which could affect the outcome for a person with no capacity. This was a breach of Regulation 20 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

We found that care plans and risk assessments did not ensure the welfare and safety of the service user. This was a breach of Regulation 9 of the health and Social Care Act 2008(Regulated Activities) Regulations 2010.

We inspected the environment and found it to be dirty in the main house. Carpets were marked and worn and we saw dirty toilet seats and commode pans. The décor was 'tired'. This area of the service was odorous. There was no pressure in any the hot water taps on the top floor resulting in only a trickle of water been available for people to have a wash. The flooring to some toilets was in need of repair and sealing. There were no bins in bathrooms. One relative told us, "The carpet is disgusting and the décor tatty in their(relationships) room"

In the newer extension it felt fresh and clean. The fixtures and fittings were more modern and were more up to date. There was an infection control policy and procedure and contracts in place for domestic and clinical waste disposal. We spoke with cleaning staff who told us they did not follow any formal cleaning rotas and just made a note when things needed doing. This meant that there were no effective systems in operation designed to maintain the cleanliness of the service and people were not living in a clean and hygienic service.

The slings that were in use were shared between people, with the exception of one person who had their own sling but there was no regular washing schedule for these shared slings which increased the risk of cross infection.

We found that people were not always protected against the risk of infection because of the lack of effective systems in the service. This was a breach of Regulation 12 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a fire risk assessment in place and people had personal evacuation plans in their care files. The individual

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moving and handling plans for service users gave them a colour coding (red, amber, green) which indicated how much support they required for their mobility. They also indicated that this colour could then be displayed on a service users door to enable staff how to prioritise them in the event of an emergency evacuation; several doors were looked at but no such colours could be found which meant that the risk assessment and plan was not consistent with current practice.

We were told by the provider that most staff had received fire safety training in November 2013 and that one of the directors had completed fire marshal training. We saw certificates in staff files verified staff were trained. The person who was fire marshal trained told us they had trained staff in the use of evacuation equipment.

When a member of staff was asked whether they had received any such training they replied that they had not. Four other staff also confirmed they had not been trained in the use of the equipment. Furthermore the first staff member spoken to did not think that they would have any role to play in the evacuation of residents in an emergency, as this had never been discussed with them. This highlighted a potential risk to service users and staff because staff roles and responsibilities had not been defined in the event of such an emergency.

Fire fighting equipment had been serviced within the preceding twelve months and regular fire alarm checks were carried out which meant that all safety precautions were in place in the event of a fire. However the staff training was not was not effective as staff were not clear about what to do in the event of a fire.

When we looked at the moving and handling equipment used within the home we saw there were only two hoists in use on the day of our inspection. This limited availability of hoisting equipment meant that hoists had to be transferred between floors. This could deter staff from following correct lifting & handling procedures and lead to staff employing unsafe practices. Three safeguarding alerts had been made to the local authority recently by visiting professionals which specifically involved unsafe practice when people had to be moved since January 2014. These alerts related to unsafe practices used by staff and meant that people were not always moved using best practice guidelines.

There was evidence that the portable hoists and other items of equipment used for lifting people had been

inspected and serviced. There was no evidence of an inventory of the slings in the home and of any regular health and safety checks for them. The director told us that they had assumed the slings were checked when the lifting equipment was serviced, but there was no evidence for this, and without a proper inventory it was difficult to see how this had been done. On one of the slings being used the Velcro hooks were extremely matted with fluff and fibres, and a member of staff commented that it could not be relied upon to be secure. This sling was taken out of service immediately by a member of staff which meant that it no longer posed a risk for people who had been transferred using a hoist.

When we looked at the electrical wiring checks we saw that recommended remedial work had not been completed. The provider arranged for this to be done on the day of our inspection. They told us they had believed it had been done. The documentation for servicing and checking of equipment was in different places and there was no system for ensuring that safety checks were carried out.

Findings from the focused inspection of 5 February 2015

We found that some action had been taken to improve safety at this service but there were still areas of concern. People who used the service told us that the staff made them feel safe and they felt their belongings were safe. One person told us, "The staff are better now than they were. The care is better, they know how to look after me" and an advocate told us, "They (person who used the service) are one hundred per cent safe."

We found that the provider had not followed the action plan they had written in respect of medicine management. There had been safeguarding alerts made to the local authority because of medication errors since the comprehensive inspection of August 2014, one of which had resulted in a nurse being reported to the Nursing and Midwifery Council (NMC).

We looked at the medicine administration records (MAR) for 11 people and looked at how medicines were handled and found that the arrangements were not always safe. The service had introduced a checking system for stocks of boxed medicines and these mainly balanced with records. However when we checked a sample of liquid

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medicines alongside the records we found that four medicines did not match up so we could not be sure if people were having their liquid medication administered correctly.

Three medicines for three people and eye drops for another person were not available. This meant that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increases the risk of harm.

All of the people who used this service had their medicines given to them by the staff. We watched a nurse giving people their medicines. They followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines.

People were not protected against the risks associated with covert administration of medication. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. When one person had medicines administered crushed and mixed with food no records were available to show how the decision to administer this medication in this way had been reached. No guidance had been sought from the pharmacist to make sure that these medicines were safe to administer in this way. Another person had medicines administered 'covertly' in food. This was not clearly documented in their care plan and therefore could be given inconsistently by different care workers. This had been identified at the inspection on 19 August 2014 but no action had been taken by the provider to ensure these people were safe.

We saw that some medicine records were not fully completed. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose.

We saw for some medicines no record had been made of any quantities carried forward from the previous month. This is necessary so accurate records of medicines are available so that staff can monitor when further medicines would need to be ordered.

The task of application of moisturising and barrier creams had been delegated to carers. Although the home had documents in place to inform carers how to apply these creams, the guidance we saw was incomplete and the

recording of the application of these products was poor. We saw the records for two people who were prescribed a cream to be applied twice daily the records showed application only at the morning dose.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that care workers did not have enough information about what medicines were prescribed for and how to safely administer them. For example the when 'required guidance' had not been updated when the prescribed medicine was changed for one person. For another person the prescribed dose had changed but the 'when required' guidance had not been updated to reflect this and the person had been given this medicine at an incorrect dose.

Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. We saw that eye drops for one person with a short shelf life once opened were still being used past the recommended date of expiry. This means that the home could not confirm that this medicine was safe to administer.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and that systems were safe. The action plan stated that "Regular medication audits" would be carried out. We found that the home had not completed a medicine audit recently. The manager showed us a new audit document which will be used in the future to identify issues. Where discrepancies had been identified we found that there was no evidence that these had been investigated or what actions had been taken to prevent them happening in the future.

We found that the service's arrangements for the management of medicines did not protect people. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the comprehensive inspection we found that staffing had not been planned with the needs of people who used the service in mind. At this visit there had been

Is the service safe?

improvements in the way in which staffing was planned and managed. We saw that the manager was using a tool to determine the number of staff needed each week. This was done looking at the needs of people who used the service. People who used the service told us there were enough staff on duty and our observations of activity in the service and the responses by staff confirmed that there were sufficient staff. On the morning of the inspection we observed that there were sufficient care and ancillary staff to meet the needs of people living at the service.

Staff were using cleaning schedules and audits which ensured the cleanliness of the building and the equipment because they were being cleaned and checked regularly. The provider told us that quotes for new carpets in the communal lounges had been received but they had not made plans to order them or have them fitted yet. Infection control audits had been completed and had identified areas needing improvement. Actions either carried out or planned were recorded. This meant that people were protected from the risks of infection because there were more robust systems in place.

We spoke with staff who told us, "There are lots of changes. There's more in house training." We saw from training records that training had been carried out for over

twenty out of thirty five staff in relation to fire safety in November and December 2014. We were told that this was an on-going process and that a new member of staff who had started work in December 2014 would now carry out a programme of on-going training which would included fire safety. We could see that fire drills had been carried out with staff and the last one recorded on 15 December 2014. The fire risk assessment and servicing of fire equipment was up to date. Manual handling assessments had previously been colour coded red, amber and green to indicate the level of support needed by people and had indicated that this coding would be reflected on bedroom doors to help staff prioritise the level of assistance a person needed in the event of a fire. We did not see them at the comprehensive inspection but at the focused inspection they had been put in place which means that the service is following their identified procedures.

Hoist slings were now listed on an inventory and safety checks carried out and recorded carried out which ensured their safety. They had been added to a the schedule of servicing along with hoists and other lifting equipment. The laundry worker confirmed that used a schedule to ensure they were washed regularly to prevent any cross infection because some slings were shared.

Is the service effective?

Our findings

Findings from the comprehensive inspection on 19 August 2014

This service was not effective. We found that the premises were not of a suitable design or layout for people. This was a breach of Regulation 15 Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

People's diverse needs were not met by the layout of the service. The corridors were narrow in the main house and had many doors opening on to them as well as equipment left in the corridors. This presented a trip hazard to people trying to move safely around the building. A safety gate had been put at the top of a steep staircase leading down from the third floor which also presented a hazard to service users and staff and had the potential to cause harm.

Communal rooms were dark and full of dated furniture and all the chairs had chair pads which gave the rooms an institutionalised feel. No attempts had been made to make anywhere look homely. Some people's bedrooms were almost devoid of any personal touches and others had been personalised with the use of people's own furniture and personal items. We did visit one person whose room was a reflection of her interests and her life. This meant that not everyone had access to personalised surroundings which reflected their likes, dislikes and interests.

There was no signage to help people with a sensory or cognitive impairment find their way around the building apart from people's names on their bedroom doors. There was no sensory stimulation or use of different coloured features such as hand rails to aid those people who were living with a dementia or to act as a memory stimulant. This meant that the environment was not adapted to suit everyone.

The dining chairs had no arms or sled bases so people could safely sit at the table. (Sled bases are a means of stabilising a chair by using wooden sleds between the back and front legs so that it can be moved safely) The lack of a sled base on chairs meant that people who had mobility problems would not be able to move the chair away from the table easily. We saw that nine out of ten people were left in their wheelchairs at lunchtime. Some people could not have sat on the dining chairs available safely because they needed some support to rest their arms.

Seven people at this service were living with dementia and their specific needs around eating and drinking had not been considered. This would have a negative impact on their wellbeing. For instance there were no pictures of food or picture signage to indicate that this was a dining room.

There was nowhere for service users or their visitors to make a drink for themselves. On the day of our inspection a person asked if they could make themselves a drink. The provider told the carer to tell them "No, not with that boiler, they can just ask."

This meant that people were being prevented from carrying on their day to day lives because the service had not put arrangements in place to allow them some independence.

Service users we spoke with told us they were well cared for by people who had the skills to look after them. Comments included, "I feel cared for", "they look after me very well, I call them "my little angels"", "Yes, I think they know what to do for me - well I hope so! They're nice girls mostly."

However one relative was concerned at the lack of clinical skills, "Some of the staff haven't got the skills to recognise when (my relative) is unwell. I've come in before now to find (my relative) unwell and when I've raised it someone actually said to me "no, (my relative) is just enjoying the music." I've got that sorted out though and they do now understand when (my relative) is unwell." Another relative said "I think (my relative) is generally looked after very well. I tell them if there's a problem and it gets sorted out one way or another. Complaining doesn't always bring results"

We saw staff had received some induction training and told us that they worked with more experienced staff when they first started working at the service. We saw that there were gaps in staff training which meant that people were not kept up to date with current best practice. One trained member of staff was asked how her training and development needs had been identified, and whether this was done within the context of her supervision, she replied that 'I've never had supervision since I've worked here'. We looked at records and saw that supervision for all staff was not up to date. This meant that staff did not have the opportunity to have protected time to discuss their work and plan their development and did not benefit from having a clear training and development plan.

Is the service effective?

People who used the service felt their health needs were met "If I need the doctor they will come the same day or the day after" "Yes, if I have a problem I tell (the clinical lead) and she sorts it out, she'll get someone to come"

One of the staff told us, "Everything we know about people is by word of mouth. We started to have a handover a few weeks ago which we haven't had before but they are not regular. This morning for instance we didn't get a handover as the nurse was busy with someone else". This meant that service users were at risk because staff did not always have up to date information about people. This had been identified at our inspection in January 2014.

One person was admitted to this service in June 2014 for end of life care and the general care plans were written on 17 July 2014. There had not been any evaluation of the care plans despite a significant change in health and well-being since admission. Appropriate risk assessments had not been completed for this person. The capacity assessment was completed but had been signed by the clinical lead which is not in line with MCA 2005 guidelines

There was access to a specialist palliative care service provided by the local hospice and a specialist nurse visited the service regularly to support the service user and the staff. A staff member said "We have specialist palliative care input for people on end of life care plans but there is no protocol". The provider had told us in their information return that they were working within The Gold Standard Framework. This was not the case with this particular service user.

No one that we spoke to was able to say their individual needs were addressed. One relative said "Things are done differently depending on how the staff are paired up. They ought to be consistent because they're only doing the same things for people day in and day out. Some try to cut corners and leave work for others". Another relative said "At weekends residents are spending half their days in bed because there's no one to get them up"

We spoke to visiting health professionals on the day of our inspection and they were satisfied that the staff were providing the care that people needed appropriately and that staff followed their advice. One health professional said that the staff were, "a good bunch of carers."

People using the service had mixed experiences around meals and mealtimes: "The food is excellent and I can eat

wherever I like really. Sometimes I like to eat in my room. You get a list to choose from" "Generally there will be something I like but if not then they'll give me something else if it's feasible" "It's alright I suppose."

When asked about the availability of snacks and drinks when they wanted them people said, "They come round at regular times with tea and biscuits but you get fed up with just that". A relative said "There are no snacks between meals and no hot drinks available other than when they do rounds." Another relative said "It depends who's bringing the trolley round as to whether visitors get offered a drink. It's not very nice for the person living here not to be able to offer their visitors a drink in what's supposed to be their home. The first thing she used to do when you went to see her before she came into Ackworth was put the kettle on. Now she can't do that for herself I think it's up to them to do it for her" A person who used the service said "There's nothing between meals and I have some snack things that people have brought me but I can't reach them where they put them."

Another person appeared to have a very different experience from most people "I get a snack whenever I want because since they found out that I don't eat the sponge cake they make because I only like fruit cake, the kitchen makes me a fruit cake one week and a fruit tea loaf the next week. I keep them here in my room in that Tupperware box. It goes down to the kitchen empty every week and comes back full. I get a drink whenever I ask for one."

One person was very concerned that their relative was not getting help with meals "I often arrive to find her splattered with a large amount of food following her attempts to eat. They keep telling me she manages very well but the only thing I think she manages well is a sandwich. I'm not bothered that she makes a mess, although she would be if she realised; I am bothered about the amount of food that she's not getting. I'm going to raise this again"

We observed a lunchtime period using SOFI. One person with a dementia needed assistance with eating and drinking and the member of staff assisting them changed three times during the course of the meal because they left to do another job or were called away. This meant that the mealtime was rushed and did not feel calm for that person. One person required special cutlery because of their

Is the service effective?

medical condition but they were given normal cutlery by staff. This meant this person may not have been able to eat properly and therefore not receive the required nutritional intake.

When asked, staff told us that if a person was not eating and drinking adequately "we put them on a three day food and fluid chart and monitor them closely" When asked what they would do if the person lost any weight they said "Oh if things aren't right we will ask for nutritional advice."

We saw from peoples care plans that the service had contacted health professionals when people required additional support with nutrition. For example one person had received advice from the Speech and Language Therapist (SALT) and another person who had some weight loss had been seen by the dietician and a plan put in place to help to help maintain their weight.

Findings from the focused inspection on 5 February 2015

We found that action had been taken to improve the effectiveness of the service. The environment had been improved through the use of worded and pictorial signage throughout the building. We found that it had been made clear where certain parts of the service were situated and where toilets and bathrooms were located. We saw that items were no longer stored on corridors making it safer for people as there were no longer hazards.

We saw that there was a large notice board in the dining room with pictures of food choices as well as menus displayed and tables set properly making the area recognisable as the dining room. There was also a board with the day, date and weather displayed. These boards helped those people living with dementia to recognise the time and place.

When we carried out the comprehensive inspection there had been nowhere for people who used the service and their visitors to make a drink and they had not been able to access snacks easily. When we returned to do the focused inspection we saw that the drinks trolley was still taken around to offer people drinks but in addition there were coffee making facilities for people to use when they wished and also snack boxes in each room containing sweet and savoury snacks. There were also cold drinks in all the

communal areas and we saw staff asking people if they would like a drink or encouraging people to do so. People could help themselves and offer guests a drink which helped people to retain some independence.

We observed breakfast which people mainly ate in their rooms and lunch in the dining room. A variety of drinks were served including water and beer and given to people in vessels appropriate to the user. We heard staff asking people who used the service what they wanted to drink and if they required a straw. People had been given a choice of lunch menu during the morning. They were given a sheet which they could complete themselves or alternatively the staff would assist them to complete their menu choices.

When we observed lunch being served we saw that the food served was of sufficient quantity and looked and smelled appetising. One person who used the service told us, "The food is excellent, there's a choice of menu and I get plenty to eat. I can get a drink anytime I want one." We saw aids in use such as plate guards to help people with eating and we observed staff being very attentive to people's needs throughout the meal.

We used SOFI during the lunch time period and saw that the dining experience was calm and peaceful which enhanced the experience for everyone but particularly for those living with a dementia

We spoke with the cook who told us, "Things are much better now. I've seen an improvement." They also told us that they were planning to review the menus and start a seasonal menu. They said, "I'm able to take things to management now and they are well received. I'm planning to get residents views for future menu choices but I do already check for satisfaction."

People who used the service told us that they were well cared for and that staff understood their care needs and knew how to look after them. One person said, "They help me dress myself. They're very good" and another person said, "They know how to assist me."

We saw from care records that mental capacity assessments were not completed correctly and there were no care plans or risk assessments in place for specific decisions. For instance one person needed their medication to be administered covertly. This means that it is put in food or drink. There was no agreement with the GP

Is the service effective?

or family recorded and no paperwork to support the decision to administer medication in this way which meant that staff did not always appear to be working in peoples best interests.

No one displayed behaviour that challenged staff at this service but staff were able to tell us how they would manage these situations if it became necessary. Staff had not received any further training on the Mental Capacity Act or Deprivation of Liberty safeguards since the comprehensive inspection of 19 August 2014. This meant that although we saw that staff understood how to seek consent and manage behaviour that challenged they may not be aware of the legal principles which supported people who lacked mental capacity.

A member of staff told us, "There's been a lot of changes. There's weekly training and more training by outside providers." Another carer said, "Courses are advertised and you can apply." When we looked at the training matrix we could see that some training had been completed in mandatory and specialist subjects since our last inspection and some had been booked. When we spoke with the

manager they told us that one of the newly employed nurses with experience in training would be taking on the role of in house training in some subjects such as Mental Capacity Act and Deprivation of Liberty safeguards. They told us that the service would continue to offer training by external providers too. Although there was some improvement evident further training needed to be completed to ensure the staff had the knowledge and skills to meet peoples needs

Communal areas were clean and smelled fresh but the lounges still had carpets that were old and marked. The provider told us that hand rails were on order to be fitted by the maintenance staff and that they would also be adapting dining chairs to add arms and sleds to make them safe to use by those people who would find it difficult to sit at the table safely. There were no changes to the furniture in the lounges and dining room at the time of our visit. This meant that the environment did not meet the needs of everyone who used the service but the provider was making some efforts to make improvements.

Is the service caring?

Our findings

Findings from the comprehensive inspection on 19 August 2014

We found that this service was not caring. Nobody we spoke with felt they were involved in planning their care and no one was aware that they had a "care plan". Two of the six relatives spoken with felt they were involved in the care planning. Only one said they were fully involved and engaged in reviewing the care. We could see that care and support plans had been written and reviewed by staff. There was no indication within the plans to show that people had been involved in planning their care.

Personal life history documents were rarely completed for people and so staff did not know people's history unless they took the time to get to know them. Staff had already told us that they rarely had time to talk with people. We did, however, see examples of some staff and service users having very good trusting relationships during our inspection. This meant that there was little evidence to suggest that people received personalised care and support.

Some people felt staff were respectful and stated that they were kind to them but some didn't feel those things. "They are respectful and we have a bit of fun", "They are all very kind." A relative said "The staff are generally ok but the manager always talks down to people" Another said "All the staff speak in a very nice and polite way, we're on first name terms but they know they can't take advantage. They always talk to (my relative) when they are doing personal care." A person using the service said "They can be harsh at times. I feel lonely, I don't like the staff, they aren't friendly" Another said "Some are very patient but some are sharp" One person said, "I love it here, I really do. They are so good to me."

We could not see any referrals to or involvement with advocates recorded in care files. We did not see any posters or information for people to access advocates. Staff spoke only of relatives advocating for people but some people told us that they did not get visitors often. Relatives and friends that we did speak to all reported that they could come and go more or less as they wished. This meant that some people may have no one to advocate for them when making decisions and choices.

We were told that two people were receiving end of life care. When we examined the documentation of a person identified as being in receipt of end of life care we found there was no care plan for end of life or for pain management. This meant the person had not been given the opportunity to choose what they wanted to happen at the end of their life and did not have a plan in place to manage their pain when it became necessary.

Findings from the focused inspection of 5 February 2015

Everyone we spoke with who used the service told us that staff were kind, polite and respectful to them. One person said, "They are polite and they speak cheerfully and yes, I feel listened to." Another person said, "There is no problem, plenty of good natured banter. Good fun." A third person said, "The staff have told me how proud they are of me, it means a lot, because of how well I've got on since I came here so ill."

During observations and discussions throughout the day we saw many examples of how well the staff knew people who used the service. The atmosphere was one of caring by staff. We saw that all the staff could speak to people who used the service about their families, former lives, likes and dislikes showing how well they knew them. There was a lot of happy chatter and banter throughout the day but we saw that people were able to be quiet if that was their preference. If anyone looked as if they were not involved staff were careful to include them.

When asked what was different about this service a staff member told us, "There's love here now."

People were asked if they felt well cared for and one person said, "The staff are better now than they were. The care is better, they know how to look after me." When asked if they had long to wait before their bell was answered they said, "They will come but I have had to wait up to an hour. It's degrading to have to wait to be cleaned up. Unfortunately I've had to get used to it but when they come they just get on with it as it's their fault." Another person said, "You don't wait very long really." We looked at the audit records relating to call bells and could see that there were two instances where two people had to wait eleven and seventeen minutes respectfully on 15 January 2015.

We spoke with the manager and they told us that they were aware of this and it had been already been discussed at a staff meeting. They had added it to the agenda of the next

Is the service caring?

meeting. They had also started to carry out random checks at different times and different days themselves to check response times. They felt that the random checks were

having an impact as the latest response times had been one and two minutes. This meant that staff were now responding to call bells in a more timely manner ensuring that they were aware of people's immediate needs.

Is the service responsive?

Our findings

Findings from comprehensive inspection of 19 August 2014

People did not always receive care when they needed it. An example of this was when we heard a call bell ringing for fifteen minutes before staff went to answer it. We saw that staff ignored the call bell despite being only yards away from the person's bedroom. They chatted for a while and then walked away in the other direction. This displayed a lack of urgency from staff and showed a lack of respect for people.

A relative said "They don't seem able to tell the difference between a bell that needs to be answered immediately and one that might be able to wait. (my relative) can't press the bell so when the call bell goes from this room you'd think they'd appreciate that I wouldn't press it unless there was a real problem. That doesn't seem to make any difference and I've had some worrying situations. It's all written down." One member of staff said, "' Much could be improved, for example the time it takes to answer bells. It's not the resident's fault that people are busy."

A relative told us that they had spoken to staff about leaving people so long when they rang the bell so that they had no choice but to "wet themselves". They said that "making people wet themselves infringed their privacy and dignity"

Another relative was concerned about the clinical skills of staff saying, "Some of the staff haven't got the skills to recognise when (my relative) is ill. They told us that staff did not always respond appropriately when their relative was taken ill. We saw staff attended when this person became ill later in the day but they did not seem to be clear about what to do and took a while to decide what they would do. This showed us that staff may not always respond to people's needs and in a timely manner.

When a service user was asked if she was comfortable when being hoisted she advised us that she did not like being hoisted and that 'I don't mind but it is uncomfortable'. When questioned as to whether she had been offered any alternative sling or means of hoisting, she replied that she had not. The records did not identify that any assessment had been carried out for this person and did not identify the specific needs of other people. For instance which individual sling to use. There did not seem

to be any system to review a person's moving and handling needs which meant that people do not have the opportunity to say when things are not right so that appropriate changes can be implemented.

There was no visible evidence of any activities taking place. People said "There are no activities" A relative said "I think there's a sing song every now and then but (my relative) doesn't join in. It's not her sort of thing". Another said "We take (my relative) out in her wheelchair for some sea air. It's lovely along the front". A staff member said "Some staff come and take the residents out in their own time, otherwise they'd never go out because there aren't enough staff." We saw some activities advertised but they seemed to happen once every two weeks.

We were told the activity organiser was working on night duty but normally they would organise activities with the help of a volunteer. When we spoke with staff about this they said this happened one day a week. There didn't appear to be any view amongst people using the service that efforts were made to help them maintain relationships with friends and family. One person said "Oh that's never been mentioned", A relative said "There are lots of people here who just need someone to come and sit with them and show some interest. You'd think the management could organise volunteers or something wouldn't you. Those people would be so much happier" This meant that there was a risk of social isolation for some people.

We looked at the complaints received by the service. There had been twelve complaints over the last twelve months. These had all been logged and the Care Quality Commission (CQC) had also been notified as is required. There was evidence of the response to the complaint and the actions taken but there was no evidence of learning from complaints.

One relative said "Yes, I'd feel that I personally could say what I wanted but you hear so much about problems for people living in homes that I'd think twice about being very contentious."

Findings from focused inspection of 5 February 2015

We found that action had been taken to be improve the responsiveness of this service but there were still areas of concern.

The overall view from people who used the service was that they got what they needed. In informal discussions with

Is the service responsive?

three people they spoke warmly of the staff taking care of them and making sure they had what they needed and said, "They always check with you that what they are doing is alright."

When we inspected care plans we could see that although some improvements had been made there were still some plans that did not reflect peoples current needs and had not been reviewed. People told us that they had heard the term care plan and understood what it was. We could see that people were given the care and support they needed in terms of their disability. For instance we saw that there was a sign in one persons bedroom telling us that they had a sensory problem which may mean they would not know we were entering the room so could we make sure they were aware. We also saw that people had their own wheelchairs and appropriate pressure relieving cushions and mattresses where needed.

We saw that staff now had the time to give care in a more person centred way because of the increase in staff hours. One person told us, "I can't speak highly enough of the service. They've(staff) have got me on my feet."

No one we spoke with had been given information about how to complain. There was a complaints policy and

procedure and records kept of complaints with associated actions. One person who used the service told us, "There's nothing to complain about but if I had a complaint I'd seek advice."

We saw that people were supported in continuing hobbies and pastimes both individually and in groups. There was a timetable of activities for each day although the activities co-ordinator only worked one day a week. Other staff led activities on other days. We saw people who used the service in their own rooms carrying out their own pastimes. One person told us, "I don't like joining in. I really like doing jigsaw so I am getting on with this." Another person told us, "There's always something going on. Last week I did cake decorating. I'm going to do knitting; we all used to do it when we were kids you know." A volunteer assisting with activities said, "It is so obvious that staff care."

We saw the activities organiser leading a group discussion; a quiet time following the exercise to music. It was clear that they had a good knowledge of the people who used the service and an open and friendly relationship with them. there were many references to preferences, choice of clothes, preferred activities, favourite films and choice of music during the discussion with input from everyone and lots of laughter.

Is the service well-led?

Our findings

Findings from the comprehensive inspection of 19 August 2014

We found that this service was not well led. The provider did not identify, assess and manage risks relating to health, welfare and safety of service users or the quality of the service. This is a breach of Regulation 10 health and Social Care Act 2008(Regulated Activities) 2010.

We asked the provider to show us any audits that had been carried out. When we asked to look at quality assurance documents we saw clinical audits had been carried out in relation to infections, wounds, skin integrity and care plans. These were limited and some out of date with very little detail and did not reflect any evidence of analysis. We came across an audit about people who needed assistance to eat and drink. The title of this document was “Feeds”, a reference to people who required assistance to eat and drink. When we asked for the medication audits we were told that the nurse had them at home and so they were not available. The audits we saw were purely factual and there was no evidence of analysis or description of how learning or improvement had taken place.

We were not shown any environmental audits. There were no equipment audits for commodes, shower chairs, or hoist slings although we were able to see that the hoists had been checked. Accidents and incidents had been recorded but no learning had taken place or improvements made.

There had not been a registered manager at this service since December 2013. One of the directors had applied to CQC to be registered as the manager but had not met the requirements for a registered manager as defined in Regulation 6(1) and (2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Health and Social Care Act (2008). They are acting as the manager until the provider is able to recruit a suitable manager.

The service had not got strong values and none of the staff we asked could define the company values. Leadership was inconsistent and weak. The directors took an active role within the service but this had led to some decisions being made which had raised concerns. The directors had

recognised that their involvement in clinical matters was not appropriate as they had no training and had tried to counter this by employing a clinical lead nurse who was making efforts to improve the quality of care in the service.

People told us when asked about the leadership of this service, "They could do a lot better. They could learn a lot from other places", and said, "The clinical lead is very good with residents although she can be very brusque and difficult with the staff". The clinical lead nurse was employed by the service to lead the staff team giving support and guidance on clinical matters. A relative said about the directors, "They don't show good leadership to the team, I don't think they know what people do or what they should be doing."

We found care was not always guided by best practice. For instance people were not always supported and supervised during mealtimes and medication management did not follow accepted guidelines. Staff were not adequately supervised as there was only one nurse on duty and staff and visitors told us that the directors mainly stayed in the office as a remote presence. This meant that staff were not receiving the leadership and support needed to maintain high standards.

Communication was poor and information was not shared with people using the service, staff or relatives. One relative told us, "Communication is lacking sometimes". One person said that they had asked for information regarding the use of money raised through charity events to benefit people who used the service. They had not received a response. We were told by one person that some of the money raised for people at this service had been used to buy a hot cupboard for food. When we spoke with the provider they told us that they had used some of the money raised as the money had been raised for this purpose.

The provider told us when they completed the information return that 95% of staff had a named person providing them with supervision. When we looked at records most staff had not had supervision and one staff told us they had never had supervision whilst working at this service. The information was misleading.

Findings from the focused inspection of 5 February 2015

We found that some improvements had been made since the comprehensive inspection of 19 August 2014 but there

Is the service well-led?

were still areas of concern. The provider had started to identify risks and areas for improvement. They had in some cases carried out assessments and audits of those areas but there was not always evidence of actions taken and learning from incidents. An audit programme had been started by the provider for 2015.

We asked the provider to show us audits that had been carried out. We saw an audit for infection control which was detailed and had associated actions attached. For instance it had been identified in the audit of 22 December 2014 "Carpet to replace" stating that action was taken on 30 September 2014 and that it was "On the in house maintenance schedule for improvement". However, we saw that the carpets had not been replaced. We asked the provider about this and they told us that a quote had been sought for new carpets but they said that they had not yet made a decision about when they would be replaced which meant that some improvements were still not in place. The five year maintenance plan 2010-2015 updated in September 2014 stated that lounge carpet was part of the providers commitment.

No medication or care plan audits had been carried out and we found that there were areas that required improvement. For instance where discrepancies had been identified by staff we did not see evidence that they had been investigated or what actions had been taken to prevent the same thing happening in the future. One person was identified at the comprehensive inspection of 19 August as receiving their medication covertly. Staff had not ensured that the correct documentation was in place to support this decision. When we checked the MAR and care plan for this person at the focused inspection of 5 February 2015 we saw that they still had no documentation in place but continued to receive their medication in this way.

Improvements had been made to environmental audits and areas of concern at the comprehensive inspection such as hoist sling safety had been reviewed. The provider had had all the hoist slings serviced and had created a register of slings used which were referenced clearly which meant that people who required the use of a hoist were been assisted using safe equipment.

There had not been a registered manager at this service at the comprehensive inspection but we found at the focused inspection of 5 February 2015 that there was a manager in place who had applied to be registered with the Care Quality Commission. This meant that the provider was taking steps to improve the leadership at the service.

When people who used the service, relatives, friends and staff were asked about the leadership of the service they told us that things had improved with the arrival of the senior nurses. When we explored this further we found that a nurse manager and two qualified nurses had been employed since the comprehensive inspection. One person told us, "Things have much improved since the senior nurses came." A member of staff described the management (providers) as having become more relaxed saying, "Team work is much better, there's more open discussion."

One staff member said, "Its much better. I've enjoyed my job again over the last few months. Its been a lot of hard work but we're all working together and morale is much improved. I'm also involved in staff meetings. Everyone is doing so much more with the residents." These comments all demonstrate that there have been improvements made at this service that have been recognised by staff, people who used the service as well as visitors. We saw that staff were now supported with regular supervision and training.

Staff were able to describe the different culture that was developing at this service and were able to describe their roles. We saw and heard from comments made that there was a determination from all the staff that things would continue to improve. All staff spoke about feeling more involved and being part of one team. This was a positive change in attitude in comparison to what we had been told at the comprehensive inspection on 19 August 2015. We noted a more positive atmosphere at the service and saw that although cosmetic improvements were still needed the service was clean and fresh.

A visitor told us, "I can see improvements since the last inspection. I have attended relatives and friends meetings where updates are given." A person who used the service said, "I can't speak highly enough of the service." A staff member said, "Its been a wake up call for all of us but lots of improvements have been made."