Ash Hall Limited

Ash Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 5 March 2018 and 6 March 2018. The inspection was unannounced. At the last inspection we found breaches in regulations. The service were not ensuring that people were consenting to their care and where unable processes were not in place to ensure decisions were made in people's best interests. We also found that the service lacked monitoring systems to enable poor care to be identified and mitigated. Following the last inspection, we asked the provider to complete an action plan to show how they would meet the regulations and when they would be compliant. At this inspection, we found that the required improvements had not been made and we found further breaches in Regulations.

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

Ash Hall Nursing Home accommodates up to 60 people in one adapted building. At the time of the inspection there were 45 people using the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was a registered manager at the service. 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.

At this inspection we identified 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. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a lack of governance in the service and the provider did not have effective systems in place to consistently assess, monitor and improve the quality of care. This meant that poor care was not identified and rectified by the manager and provider.

Risks to people's health and wellbeing were not consistently identified, managed or followed to keep people safe.

We found there were not enough staff available or effectively deployed to deliver people's planned care or to keep people safe. Staff had not always received training to enable them to carry out their role effectively.

We found that medicines were not administered in a consistent and safe manner and they were not always administered as prescribed.

People were not always safeguarded from abuse because staff had not always recognised possible abuse, which meant people were at risk of unlawful restrictions.

Infection control risks had not been mitigated to protect people from harm.

When people did not have the ability to make decisions about their care, the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were not followed. These requirements ensure that where appropriate, decisions are made in people's best interests when they are unable to do this for themselves

People did not always get the support they needed to drink sufficient amounts. This meant some people's hydration needs were not met.

Advice was sought from health and social care professionals when people were unwell. However, we saw that these were not always followed to ensure their health needs and social care needs were met effectively.

Improvements were needed to ensure the environment was safe and met people's needs.

People told us they were treated with care and given choices. We saw that improvements were needed to ensure that staff were available to provide care in an unrushed way and choices were not always promoted in a way that met people's individual understanding. People were not always consistently treated with dignity.

Improvements were needed to ensure people's preferences including cultural and diverse needs were assessed and considered to enable individualised care provision that met people's preferences.

Improvements were needed to ensure that people's end of life wishes were assessed and recorded.

People had the opportunity to participate in interests and hobbies that met their preferences.

People knew how to complain about their care and the provider had a complaints policy available for people and their relatives.

People and staff told us that the registered manager was approachable and staff felt supported to carry out their role.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's risks were not always mitigated and staff were not always aware of people's up to date risks, which meant people were at risk of unsafe and inappropriate support.

People were not always safeguarded from abuse because staff had not always recognised possible abuse. People were at risk of unlawful restrictions.

There were not enough staff available and staff were not deployed to meet people's needs in a safe and timely manner.

Medicines were not managed safely to protect people from harm.

Infection control risks had not been mitigated to protect people from harm.

Is the service effective?

Inadequate

The service was not effective.

The provider had not acted in accordance with legal requirements to ensure that decisions were made in people's best interests and in the least restrictive way

Improvements were needed to ensure that staff were adequately trained to carry out their role.

People's risk of dehydration was not acted on to protect them from the risk of harm.

People were happy with the quality of the food. However, some improvements were needed to enable people to make informed choice at mealtimes.

Advice received from professionals was not always followed to maintain people's health and wellbeing and improvements were needed to ensure the environment was safe and met people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were caring. However, people did not always receive caring support because the provider had not ensured there were enough staff available to provided unrushed care and support.

People were not always cared for in a dignified way and improvements were needed to ensure people's choices were promoted in line with their understanding.

People's right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements were needed to ensure people's preferences including cultural and diverse needs were assessed and considered to enable individualised care provision that met people's preferences.

Improvements were needed to ensure that people's end of life wishes were assessed and recorded.

People had the opportunity to participate in interests and hobbies that met their preferences.

There was a complaints procedure available for people and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of oversight and governance within the service and there were no clear levels of management and accountability.

We found there were no systems in place to monitor and manage the service and mitigate risks to people. This meant that areas of poor practice had not always been identified.

Records did not always contain accurate and up to date information to ensure that people's risks were mitigated.

People, relatives and staff felt able to approach the registered

manager and the management team.

Ash Hall Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 March 2018 and 6 March 2018 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who had expert knowledge of dementia and skin care and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 reviewed the information included in the PIR along with information we held about the home. This included notifications that we had received from the provider about events that had happened at the service, which the provider was required to send us by law. For example, serious injuries and safeguarding concerns.

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

We spoke with 10 people living at Ash Hall Nursing Home, five relatives, two nurses, ten staff including the maintenance worker, the deputy manager, the registered manager, the business manager and the provider. We observed care and support in communal areas. We also spoke with a visiting professional. We viewed 13 records about people's care. We looked at how the service was managed which included six records for staff employed at the service and audits to monitor the quality of the care provided. We also viewed nine people's medication records and observed how medication was managed and administered to people.

Inadequate

Is the service safe?

Our findings

People's risks were not always managed or mitigated to keep them safe. For example; one person had been assessed as at high risk of falls. The care plan we viewed stated that this person was not to be left unsupervised whilst in their armchair. We saw that this person was left unattended in their armchair in the small lounge. We raised this issue with the registered manager who requested that staff moved this person to the large lounge where they could be supervised. However, we saw the person continued to be left unattended as there was not always staff in the lounge to supervise this person. We asked the registered manager if they had considered using chair sensors to alert staff that this person was attempting to mobilise. The registered manager told us, "No, we have nothing like that here". Another person had fallen on two occasions in the lounge. The records we viewed stated that this person needed to sit in a different lounge where staff were able to supervise them to lower their risk of falling. We saw that this person was in the small lounge and there was no staff supervision. We observed this person try to get out of the chair on two occasions and there were no staff available to ensure this person's risk of falling was reduced. This meant people were at risk of harm because their assessed risk of falling was not managed or mitigated to protect them from the risk of harm.

People's risks whilst they were in bed had not been mitigated to keep them safe from harm. For example; the incident records we viewed showed that one person had been found on the floor on their crash mat. The incident record stated that this person had climbed over their bedrails. The risk assessment we viewed did not show the actions taken to lower the risk of a further occurrence. We asked the registered manager if this person had been assessed for a low bed due to their risk of climbing over the bedrails and falling. The registered manager told us that they did not have enough low beds available for this person to use. Another person had fallen from bed because they had climbed over their bedrails. The care plan and risk assessment we viewed had not been updated to show the measures in place to protect this person from the risk of further falls and climbing over their bedrails. The registered manager told us that they had not completed a falls risk assessment and this was something they needed to complete. This meant that people were at risk of harm because their risk of falling from bed had not been mitigated to protect them from harm.

People were not always supported by staff consistently when they displayed behaviour that may challenge services. For example; staff we spoke with explained how one person needed to be supported when they displayed behaviour that may challenge. However, we saw that staff did not always support this person consistently. For example; we saw this person become anxious and was experiencing agitation. We saw one member of staff speak with the person in a loud way, which did not relieve this person's anxiety. We saw another member of staff bend down and speak with the person calmly and quietly and the person responded to this well. This person's care plan did not contain this important information to provide guidance for staff to follow to provide appropriate support that met this person's needs. We were unable to assess the instances of agitation as these had not always been recorded as required. This meant that this person received inconsistent care that did not always meet their needs.

We saw that a number of people were assessed as being at high risk of developing pressure sores and topical creams had been prescribed to mitigate the risk of them developing pressure sores. We saw that

Topical Medicine Administration Records (TMARs)were not in place for people who required creams administering by care staff, which meant we were unable to assess whether people were receiving their topical medicines as required. For example; one person told us that they were sore whilst sitting in their chair. We checked their records and they had areas of sore skin and were at risk of pressure damage. We saw that this person had been prescribed a cream to protect their skin. We asked to look at the TMARs but there were no TMARs in place or records to show that this person had been administered this cream to lower the risk of breakdown to their skin. The registered manager was unable to confirm whether this person had been supported with their prescribed creams. This meant that this person was at risk of harm because we could not be assured that the cream prescribed had been administered and therefore we could not be satisfied that the risk to their skin was being addressed.

We saw that there was no information available to staff for the administration of 'as required' medicines to ensure that these medicines were given in a consistent way by the staff. For example; one person suffered periods of anxiety and had been prescribed an 'as required' medicine to be administered. There were no protocols in place to give staff guidance to understand when this person needed their medicine. We saw that this person had been administered their medicine, but the records did not show why this person had received this medicine, which meant we were unable to assess if they had received their medicine as prescribed. We spoke to the registered manager and the deputy manager who agreed that this information would help staff to understand and decide when it would be most appropriate to administer these medicines. This meant that people were at risk of receiving their medicines in an unsafe manner because staff did not have sufficient guidance to follow.

The above evidence shows that people's risks were not planned, monitored or mitigated in a way that kept them safe from harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient numbers of staff working in the home. People we spoke told us that they had to wait long periods of time to be supported to access the toilet. We saw one person asked a member of staff if they could go to the toilet. This member of staff went to get someone to help them. We saw there was a delay of 10 minutes before this person was supported and they said, "I'm still waiting and it's very uncomfortable''. This person began to cry out to staff and said, "Oh, oh, oh hurry up". A relative said, "The only problem is not enough staff to get people to the toilet. It's not just with our relative. We've seen others wait a long time to be taken to the toilet". Another relative said, "We have noticed with people who need hoisting that there is a long wait if they need the toilet". This meant staff were not always available when people needed them.

We saw that communal areas were left unattended and heard people shouting in their rooms for assistance from staff. For example; we heard one person shouting from their room. We found that there was not a call bell accessible for this person to use. This person was in a distressed state. There were no staff in the area to hear this person calling for them and they had no other means to call for assistance. The registered manager referring to this incident told us, "I know and you know this is really not acceptable is it?" We viewed the care plan for this person which stated the call bell should be left in reach irrespective of the person's ability. Another person was heard shouting for assistance. They said, "I have been waiting for a long time. I want to get up. Staff came into me and said they would come back but I am still waiting. I want to get up now but I can't do this by myself". Staff told us there were not enough staff available to people and people often experienced delays in receiving support to meet their care needs. One staff member said, "People have to wait for their personal care as we can't get round to people. We don't even have time to spend five minutes with people. This meant that there were not enough staff deployed across the service effectively to meet people's needs in a timely way.

We saw that people had to wait long periods of time to be supported with their personal care needs. We were informed by staff and we saw that two people were not supported with their personal care needs until 12.30p.m. We looked at these people's care plans and saw that one person had been assessed at high risk of pressure damage and their skin was vulnerable. We saw that this person did not have a current pressure sore but they were at heightened risk of damage to their skin because personal care was not provided in a timely manner. The staff and the daily records confirmed that this person had not had their personal care needs met since the previous evening. We also saw that another person had been assessed at high risk of pressure damage. This person had last been supported with their continence needs at 4a.m and we saw that they had not been supported until 12.30p.m. This meant that these people were at risk of harm because their risks to their skin had not been mitigated due to staff being unavailable to provide this support in a timely manner.

We asked the registered manager and business manager how they assessed that there were sufficient staff to meet people's needs. We were told they did not have a specific system to assess the amount of staff in line with the dependency of people living at the home. This meant that there was no system in place to ensure that the staffing levels were regularly assessed to ensure there were enough staff available as people's needs changed.

The above evidence shows that people did not always have their needs met in a timely way because staff were not deployed effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had a recruitment policy in place and checks were carried out on staff before they provided support to people. These checks included criminal record checks that had been undertaken which ensured staff employed were suitable to provide support to people who used the service. Some improvements were needed to ensure that references from previous employers were received for all staff employed at the service.

People and their relatives told us that they felt they were safe when staff supported them. One person said, "I know I'm safe and looked after. I am moved by hoist and staff know what they are doing. They are very careful". One relative said, "My relative seems safe here to us. We've seen them being hoisted and they do it very carefully. They talk to them all the time they're doing it". Staff we spoke with told us they would report concerns immediately to the registered manager. We saw that the registered manager had reported alleged abuse to the local safeguarding authority. However, we found that in some instances people had not been safeguarded from potential harm. For example; staff had not recognised that people who had not been supported in a timely way could constitute abuse and had not considered reporting this practice with the appropriate authorities. This meant that people were not always safeguarded from potential abuse.

Infection control risks had not always been acted on to protect people from the risk of infection. We found that two chairs in the lounge were posing an infection control risk to people because they were dirty and had rips in the fabric. This had not been raised or detected as a concern by the registered manager. We also found that four mattresses were not fit for purpose. Two mattresses were heavily stained with bodily fluids which had leaked through to the foam and posed a risk of infection to people. One person was at high risk of pressure damage and had been assessed as needing a pro-pad mattress to reduce the risk of skin breakdown. However, this was compromised and there was a risk that this was not effective. We also found two pro-pad cushions that were stained. We found that three bedrail covers were ripped and posed an infection risk. We showed the registered manager and provider the issues we had found. The provider said, "This is disgusting. We need something in place to ensure these mattresses are looked at everyday". We were told and we saw records that confirmed the maintenance worker had started to replace some of the

mattresses in the service and we were told the concerns raised would be acted on by the end of the inspection. We saw that this had been carried out which ensured people's immediate risk of infection and cross contamination had been lowered.

Inadequate

Is the service effective?

Our findings

At our last inspection on 19 December 2016, we found that people's ability to consent to their care had not been assessed and we could not be assured that care was provided in people's best interests. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had not been made and the provider remained in breach of the regulations.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that mental capacity assessments had been carried to identify whether people had the capacity to consent to the use of bedrails to keep them safe. However, there were no capacity assessments in any other areas of people's care and treatment. Where people had been assessed as lacking the capacity to consent to the use of bedrails we found there had been no best interest assessments or discussions to ensure that this was carried out in the person's best interests line with the principles of the Act. We asked the registered manager about the MCA and found that the registered manager lacked knowledge and insight into their responsibilities under the MCA to ensure people received care in their best interests and in the least restrictive way possible. This meant people were at risk of receiving care and treatment that was not in their best interests.

We looked at the DoLS that were authorised and awaiting authorisation by the local authority. We asked the registered manager if any of the authorised DoLs contained conditions that they needed to follow and we were told "No". However we saw that one person had an authorised DoLS put in place in July 2017. We found there were three conditions that needed immediate action and two of the conditions were not being met. Conditions are put in place by the supervisory body to ensure that the restriction is the least restrictive method as possible and in the person's best interests. This person required their bedrails to be re-assessed and the provider needed to hold a best interest assessment. We found that both these actions had not been completed. This meant that this person was not being supported in line with their DoLS and they were at risk of being unlawfully restricted.

People were not always safeguarded from potential unlawful restrictions. We saw that one person had been assessed by a physiotherapist who had stated that they were responsive to therapy and able to use the

stand aid. A stand aid is a piece of equipment that staff can use to assist people to stand. The records showed that on the following day to this assessment this person was being cared for in bed and the care plan stated 'due to frailty'. A Deprivation of liberty safeguard (DoLS) had been submitted for this person which related to the use of bedrails, but this had not included that they were being cared for in bed. This was a potential restriction against this person and this person was at risk of being unlawfully restricted as there had been no best interest assessment or DoLS referral made for this. The registered manager told us that they would contact other professionals involved in this person's care to undertake a review and they would then include this on their DoLS referral. This meant this person was not safeguarded from the risk of improper restrictions because action had not been taken to ensure this person being cared for in bed was in their best interests and was lawful.

The above evidence shows that provider did not act in accordance with the Mental Capacity Act 2005. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received an induction when they were employed at the service. This included training to help them provide care effectively. Staff told us that they had received regular updates in training. However, staff were unable to explain their responsibilities in line with the MCA and did not have a clear understanding of DoLS. We saw that staff had not been trained in this area. The registered manager also had a poor understanding of the MCA and DoLS which meant that they were unable to provide guidance and support to staff in this area. This had been raised at our last inspection in December 2016 and we were informed that staff would be trained in the MCA and DoLS by February 2017. The registered manager and provider stated that they had experienced difficulties in accessing training. However, this had now been arranged and scheduled for staff to attend. We found that people's medicines were not managed and although staff had received training in medicines management we found that staff and the registered manager had not ensured people's medicines were managed safely. This meant that staff were not always competent to carry out support to people in a safe and effective way.

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

We found that people that were at risk of dehydration were not having their fluid intake monitored effectively leaving them at risk of harm. For example; one person was at risk of dehydration and the registered manager had assessed this person needed to meet a fluid target of 1311mls a day. The fluid intake charts we viewed for this person showed that on three occasions within one week this person did not meet their assessed target. Another person was at high risk of dehydration and we saw that they had a target of 1503mls a day. The fluid charts we viewed showed that over a 14 day period they had not met their target and the records showed that they had drank extremely low amounts. We fed back our findings to the registered manager who told us they were not aware that these people had not met their assessed targets. We asked the registered manager about this who told us that if people's fluid intake was below 500mls in an afternoon then an allocated worker would ensure fluids were regularly encouraged. We were told by the registered manager and the deputy manager that a signature, time and allocated worker would be recorded on the charts to show this had been completed. The charts we viewed showed that this had not been carried out. We found that the registered manager did not have a system in place to monitor people's fluid charts to ensure that people had drank enough throughout the day and they had failed to identify that people who were at high risk of dehydration had not drank enough fluids. This meant that people were at risk of dehydration because their assessed risks had not been mitigated to ensure sufficient levels of fluid were provided to maintain their health and wellbeing.

The above evidence shows that people's hydration needs were not always met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found concerns with people receiving enough fluids people told us that they enjoyed the food provided. One person said, "The food is pretty good and they [staff] are always offering drinks". Another person said, "The meals are very good. I usually have porridge for breakfast". A relative said, "My relative is happy with the food and it looks good. They are happy with the choice of sandwiches at teatime". We saw that staff supported people who need assistance to eat in a patient manner and chatted to people throughout the meal in the dining area. Some improvements were needed to the choices on offer to people. For example; we saw that there were two choices on offer on the menu. However, when the meal arrived there was only one meal on offer. The cook told us that if people wanted something different they could ask and they would go and make something for them. We saw that when meals were taken to people they were not asked by staff if they wanted the meal on offer so this did not promote choice for people at lunchtime. We also saw that the menu on each table was small print and consideration had not been given to people who had poor eyesight or were unable to understand the menus e.g. there were no picture menus to inform choices. This meant that some improvements were needed to ensure people were able to make informed choices at mealtimes.

People told us that they were able to access health professionals when they needed to, such as doctors, chiropodists and opticians. One person said, "The Doctor sees me every week as I am diabetic". One relative said, "The GP is in regularly and the Home were quick to act over a recent chest infection''. We spoke with a visiting professional who told us that referrals for advice were appropriate and the registered manager sought guidance when needed. However, we saw that advice provided was not always followed when people's health and emotional wellbeing had deteriorated. For example; we saw that advice received about one person's mobility had not been followed which put them at risk of further falls. Another person had been visited by a Community Psychiatric Nurse (CPN) because they started to display behaviour that may challenge. The CPN requested that a behaviour chart was put in place on the 2 March 2017 with immediate effect. We asked staff about these charts on the first day of the inspection and they were not aware that these needed to be completed. We saw that this person became agitated later that day and requested the behaviour chart on the 2nd day of inspection. However, this had not been completed as required. The deputy manager put these in place after our feedback. We will assess whether these have been completed at our next inspection. This meant that advice had not been followed to maintain people's health, safety and wellbeing.

We found that environmental risks had not been assessed to protect people from the risk of harm. For example; we saw that people were not protected from potential burning risk from hot radiators. We saw that radiators within the service did not have protective covers to ensure that when temperatures were high people were protected from the risk of harm. During the inspection we felt radiators that were very hot to touch and were in areas that could be accessed by people independently without staff supervision. We asked the registered manager and provide about this and they told us that due to certain areas of the service being old they had found it difficult to source covers for the radiators. There were no risk assessments in place to identify the potential hazards to people and what action could be taken to reduce these risks. We also saw two doors which were sign posted 'no unauthorised access'. However, there was a key available on a chain next to the lock on each of the doors. One of the doors was to the boiler and could pose a risk to people if they entered the room. The provider told us that these doors had always had the keys attached and there were no risk assessments in place to identify potential hazards to people. This meant that people were at risk of harm because environmental risks had not been assessed or mitigated.

We found that before a person used the service an assessment of their needs was to ensure that the person's

needs could be met at the service. We saw that information was gathered from the person themselves, family members and any other representatives that were involved in the person's life. This information included details such as; the person's past medical history, physical and emotional needs and people's likes and dislikes. However, we found that the assessment form did not detail specific information about people's diverse needs such as cultural background, religion or their sexuality. We fed this back to the registered manager who stated that they would ensure that a care plan was implemented to include an assessment of people's diverse needs. This meant improvements were needed to ensure that people's diverse needs were assessed and planned for.

Requires Improvement

Is the service caring?

Our findings

We saw that staff were very busy and people could not always get staff attention and people were observed calling out for support. Staff we spoke with told us they did not have enough time to give to people as they were very busy, which impacted on their care. One staff member became upset and they told us they wanted to be able to provide meaningful care to people but were unable to because they knew other people were waiting for support. This meant that people were not always supported in a caring way because staff did not always have enough time to spend with people.

We found that people's dignity was not always considered. For example, we heard staff talking about people in the dining room where other people were sat. We observed staff shouting across the dining area to each other asking who needed "feeding" and discussing who they would "feed" next. The language used to ask who needed assisting to eat their lunch was undignified and staff had not considered that the use of this language was inappropriate. This meant that people were not always supported in a way that protected their dignity.

People told us staff gave them choices in the way they received their care. One person said, "I like to get up when the night staff are on. They get me ready while it's quiet which I like". Another person said, "The staff help me to get dressed and I choose what I want to wear each day". People told us and we saw that people were dressed individually and were given choices in the clothes that they preferred to wear. We saw people were given choices by staff throughout the day such as; where people wanted to sit and what they wanted to drink. Staff listened to people and carried out support in line with their wishes. However, some improvements were needed to ensure that people were given choices all aspects of their care. For example; we saw that plastic beakers were provided to each person at the service when hot drinks were provided. We asked the registered manager and business manager why people were not provided with ceramic cups to enjoy their drinks from. Both the registered manager and business manager told us that some people needed plastic beakers to meet their needs and for their safety. They agreed that people who were able should be given the choice of drinking out of a cup. This meant that people were at risk of receiving institutionalised care because their individual needs and choices had not been considered.

We found that ways to promote people's informed choice had not always been considered. For example; we saw that large print or pictorial information was not available for people who had difficulty with their sight to ensure that everyone that used the service had the same information made available to them. The building was large and had many corridors and there was a lack of information to enable people to orientate themselves when moving around the service to access their bedrooms and toilets where they were independently mobile. This meant that the provider had not ensured that information was available in a format that all people who used the service could understand.

Although we saw some undignified practices people told us they were happy with the way the staff supported them and staff were kind and caring. One person said, "[Staff name] is very gentle, and one staff member always say 'Hello Beautiful', which makes me feel good". Another person said, "I am happy here. All the staff are very friendly and kind". A relative said, "The staff here are a friendly bunch. [Staff name] is very

caring. You see staff giving lots of hugs". We saw when staff supported people they did so in a kind and caring way and the interactions we saw were positive. People also told us that staff protected their dignity when personal care was provided and people's privacy was up held. One person said, "When I'm having a bath they always put a towel across my lap when I am on the seat so that I don't feel embarrassed". Another person told us that they liked to stay in their room and the staff respected their privacy. The person said, "I like to spend time on my own in my room. Staff pop round every now and then to check I am okay".

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us and care records showed that they were involved in the assessment and planning of their care. One person said, "We've been involved with the care plan and a social worker comes every twelve months to discuss things with me". Another person said, "I have been involved in my care plan". Staff we spoke with had a good understanding of people's preferences and the way people like their care providing. We saw care plans contained some individualised accounts of the people's care needs and how staff needed to provide support in a way that suited the person. However, some of the records we viewed contained generic assessments and were not specific to people's individual needs such as; people's dementia care plan and people's food and drink preferences. This meant that some improvements were needed to ensure that people's individual preferences were consistently sought and recorded.

We found that people's diverse needs were not always assessed before they started to use the service and this important information was not available to staff. For example; people's cultural and religious preferences had not been taken into account to ensure that this part of their life was maintained. We also found that other diverse needs such as sexuality had not been considered at the assessment stage and people's sexual orientation were not detailed in the care records. We fed this back to the management team at the close of the inspection and the management team felt that it was difficult to ask people questions that may be sensitive. However, this information may also be an important part of people's past life and it is important that the registered manager is able to incorporate people's diverse needs as part of the overall assessment of people's needs and preferences. This meant that there was a risk that people were not receiving a fully personalised service because all aspects of their life had not been considered.

People told us that there were some activities on offer such as; exercise to music, watching films and external entertainers. One person said, "We get regular entertainers often in the clubhouse so it's an event. I've done some arts and crafts. I go to the church service sometimes". Another person said, "The Activities lady is good. I enjoy the entertainers and the virtual tours we have on film. I join in the armchair exercises and musical instruments. School children come in and I think that's for a Teddy bear's picnic. The only thing I would like is to get out in the fresh air a bit more". A relative said, "My relative enjoys the entertainers and did used to enjoy quizzes". There was an activity co-ordinator at the service who planned activities and supported people with various activities. This member of staff was responsible for providing mental stimulation and 121 activities for 45 people in communal lounges and in bedrooms. During the inspection we found that people spent long periods of time sitting in lounges with very little interaction. Staff did not have time to spend with people and the activity worker was with other people in their rooms. This meant that some improvements were needed to ensure that people's social health needs were consistently met.

We saw some reviews had been completed. However, where people's needs had changed the staff were not always aware of the changes to how people needed supporting. Staff told us they did not have time to access care plans but there was a handover at each shift to pass on any details of people's care from the previous staff on shift. We viewed the handover record and found that the information lacked detail and did not clearly reflect people's needs. We fed back this to the management team who agreed that more detailed information on the handovers would ensure that staff were aware of people's changing needs. This meant

that improvements were needed to ensure staff were provided with detailed information about people's changing needs to enable the provision of consistent care.

We found that some improvements were needed to the advanced planning to include people's end of life preferences and wishes. We saw that information was available regarding people's decision for a 'Do Not Resuscitation' (DNAR) order to be in place. A DNAR is a document issued and signed by a doctor, which informs a person's medical team that they do not wish to be resuscitated. We saw that one person had an end of life care plan in place. The care plan stated 'I wish for a quality death with all goals chosen by myself and met with assistance from staff' The care plan did not detail this person's individual preferences or wishes to give staff guidance on the way this person wanted to be support at the end of their life. This meant that improvements were needed to ensure that information regarding people's wishes at the end of their life was assessed and recorded.

People and their relatives told us they knew how to complain. One person said, "If I had any issues I'd talk to any member of staff or if needed I would speak to the Manager". The provider had a complaints policy in place and we saw that there was a system in place to log any complaints by the registered manager. We found that there had not been any complaints recorded at the service at the time of the inspection. We were unable to assess whether this system was effective in responding to people's complaints.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 19 December 2016, we found that systems were not in place to monitor and mitigate risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had not been made and the provider remain in breach of the regulations.

The registered manager did not have effective systems in place to monitor the service. The inspector asked the registered manager if they had any monitoring information that they could look at. The registered manager told us that these had not been completed. We found there was a lack of monitoring systems in place to identify and rectify poor practice and the registered manager was unaware of the issues highlighted at the inspection. For example, there were no systems to monitor the effectiveness of the newly implemented fluid charts. Our inspection findings highlighted that records showed people's fluid intake was extremely low however, this had not been recognised and action had not been taken to support people to increase their fluid intake. We asked the manager why these people had not received enough fluid and why the system to monitor this on a daily basis had not been completed. The registered manager said, "It's not working is it?" This meant the system in place to monitor and mitigate people's hydration risks was not effective, which put them at heightened risk of dehydration.

The system in place to ensure that infection control risks were prevented was not always effective. The service had been visited by the infection control team who had raised concerns and forwarded a report to the provider which contained actions to complete. We saw that there were continued infection risks to people which had not been swiftly identified by the registered manager. For example; we saw that mattresses and cushions posed an infection risk and there was furniture that was ripped which posed an infection risk to people. We asked the registered manager if they had a system to audit infection risks throughout the service and we were told they had started to undertake mattress checks but they did not have an infection control audit in place.

There was not a system in place to check that all medicines were managed safely. The deputy manager showed us a system that they had implemented for some medicines. However, boxed medicines and topical creams were not monitored and we were unable to assess whether people had their medicines as required. For example, we saw that topical creams were not always recorded and the registered manager was not aware whether people had received their topical creams as prescribed. This meant people were at risk of not receiving their medicines as prescribed as there was not a system in place for the registered manager to ensure these were provided.

We found areas of risk regarding the environment. For example; we saw that radiators did not have covers to protect people from the risk of burns and there were areas of unauthorised access to people that had keys attached, which meant there was a risk that people could access these unsafe areas. We asked the registered manager if they had a health and safety/environmental audit in place to check that areas of the service were safe for people. The registered manager told us they did not undertake this type of audit and was unaware of the potential dangers to people we had found at the inspection. This meant that risks to

people had not been monitored or mitigated to protect them from harm.

Accurate records had not been kept when people's needs had changed. We found the records did not contain sufficient up to date information for staff to follow to support people safely. For example; one person care plans stated that they were at risk of falls but there was no risk assessment in place to give staff guidance on how this person needed to be supported to lower their risk of falls. We saw that another person had fallen from their bed my climbing over their bedrails. However, the risk assessment and care plan had not been updated after this accident to lower the risk of a further accident. We asked the registered manager how they ensured that records were up to date and reflected the changes in people's needs. They said, "It's been difficult to keep on top of things as I've been busy in other areas". The registered manger did not have a system in place to check that records contained up to date information for staff to follow. This meant there were no systems in place to ensure that the care records contained an accurate record of people's current needs.

Timely action had not been taken to change staffing levels to ensure people were kept safe and had their needs met in a timely way. We saw that there were not enough staff available and people were at risk of unsafe and inappropriate care. For example; we saw and staff told us that people did not have their personal care needs met in a timely way and staff were not always available when people needed supervision to lower their risk of falling. We saw that staff were not always able to provide unrushed and caring support to people. The provider did not have a system in place to assess the level of staff required to meet people's changing needs. The business manager told us that they had increased the amount of staff after the inspection to ensure people's needs were met and they were supported safely. We will assess this at our next inspection. This meant there was not an effective system in place to calculate the number of staff that were required or to monitor the deployment of staff to ensure people's risks were lowered and their care was provided safely.

The registered manager did not have a clear oversight of the service and there was a lack of clear leadership within the service to provide guidance to staff and to identify poor practice to make improvements. For example; the registered manager was unaware that staff were not always carrying out their role as required to keep people safe and their mitigate risks. The registered manager told us they had been working at the service as a Nurse when there were staff shortages and this had impacted on their ability to manage the service. We found that there was an improvement plan in place to address the concerns from the local authority after their visit in December 2017. We found that some of the required actions had been completed. However, some actions were showing as completed but we saw that this had not been sustained. For example; the improvement plan stated that fluid monitoring in place but we found this was not effective in identifying when people need to be encouraged to drink more fluids. The provider did not have a system in place to ensure that the registered manager was undertaking the responsibilities of their role and they were making the required improvements in line with the local authority action plan. The provider had failed to ensure that people were protected from harm because they were not aware of how the service was being managed to keep people safe. This put people at risk of harm because there were no systems in place to ensure that people's risks were mitigated to protect them from harm. The business manager told us that they had purchased a new auditing system which will be implemented at the service and they would be monitoring and managing the registered manager's role to ensure that action will be completed as required. This meant there had been a lack of leadership and governance in the service which had resulted in people being exposed to the continuing risk of harm.

The culture within the service was task focused and people were not always treated in a respectful way. The management was unorganised and this had led to failings within the service. The lack of governance at the service meant that the provider had not recognised the areas of concern identified at the inspection and

had not put systems in place to mitigate risks to people. The provider had not checked to ensure people were receiving a service that was safe, effective, responsive and caring because the service was not well led.

The above evidence shows that effective systems were not in place to monitor, manage and mitigate risks to people and protect them from harm. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff we spoke with told us that the registered manager and management team were approachable and they were available at the service on a daily basis. One person said, "I know the manager she's always about". Another person said, "I know the owner and the daughters who work here as well [person named them]. I'm not sure about the manager though". "A relative said, "Any issues I know the Manager and other senior people. I've never had to read the riot act. If I've asked for something to be done it's been okay". Staff told us that they felt able to approach the registered manager if they had any concerns and they had recently received supervision with the registered manager to discuss their role and development. This meant that people and staff felt able to approach and raise any concerns to the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People's hydration needs were not always met.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider did not act in accordance with the Mental Capacity Act 2005., which meant people were at risk of receiving care that was not in their best interests and not in the least restrictive way possible.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's risks were not planned, monitored or mitigated in a way that kept them safe from harm and medicine management was not safe.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Effective systems were not in place to monitor, manage and mitigate risks to people and protect them from harm.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	People did not always have their needs met in a timely way because staff were not deployed effectively.

The enforcement action we took:

We served an urgent Notice of Decision to impose conditions on the provider's registration.