Laudcare Limited

Avonmead Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out this inspection over three days on the 23 November, 3 and 8 December 2015. The first day of the inspection was unannounced. During our last inspection on 22 May 2014 we found the provider satisfied the legal requirements in the areas we looked at.

Avonmead Care Home provides personal and nursing care to up to 45 people. At the time of our inspection there were 33 people living at the home.

There was a registered manager in post. 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. However, at the time of our inspection, the registered manager was on leave. The home was being managed on a day to day basis by the deputy manager. The deputy manager was being supported by senior managers who visited the home on a regular basis.

Senior managers were aware the home was not operating how they wanted it to. Prior to the inspection, there had

Summary of findings

been a number of allegations of abuse and neglect involving three members of staff. Appropriate action was taken and the investigations were in the process of being finalised. The allegations had impacted on the service and had caused some people, general anxiety and apprehension. Management and staff were working hard to encourage people to share any concerns they might have, without fear of reprisal. Actions were being taken to improve the service people received.

People, their relatives and staff raised concerns about staffing shortages and the impact this had. This included people waiting for assistance and staff saying they were not able to provide the level of care they wanted. There was some concern that people's level of dependency was high and staffing levels did not take this into account. Senior managers had asked staff for evidence of staffing shortfalls and were in the process of reviewing the information.

There were some shortfalls with the management of people's medicines. One person had not been given their medicines, as prescribed. Once this was identified, an immediate investigation was undertaken and action taken to minimise further occurrences. Staff had not signed records to show they had applied people's topical creams and pain relief patches were not sufficiently rotated when administered. All other areas of medicine management were appropriately maintained.

Less visible areas of the home were not clean. This included debris on small tables and in the passenger lift. There was some staining to carpets, light pulls were stained brown and there were surfaces such as bed rail covers, which were worn and could not be wiped clean. More positively, corridors and some people's bedrooms were in the process of being refurbished.

Care plans were not person centred. There was information about people's basic needs but little about individual preferences or emotional and social support people required. Information detailed the treatment given to wounds but there was not a clear plan to follow. Care charts had not been consistently completed and on the first day of our inspection, some people were not adequately supported to drink sufficient fluids. The acting manager addressed this with staff and improvements were made throughout the remainder of the inspection.

The majority of people and their relatives were happy with the care provided. However, there were some comments that the care varied depending on the staff on duty. This was apparent during the inspection as some staff showed a caring approach and were friendly and respectful. They interacted well with people, were attentive and encouraged conversation. Other interactions were not so good. Some staff did not engage effectively with people and did not promote their dignity.

Staff were well supported by senior managers and each other. They received regular meetings with their supervisor, to discuss their performance and any concerns they might have. Staff undertook regular training to ensure they had the knowledge and skills to do their job effectively. Experiential learning was in the process of being organised to enable staff to feel and reflect on their experiences of receiving assistance.

People were supported by staff who had undertaken a thorough recruitment process. This ensured all staff were suitable to work with vulnerable people. Staff had received updated safeguarding training and were aware of their responsibilities to recognise and report abuse.

A comprehensive auditing system was in place to monitor and review the quality and safety of the service. The system ensured any shortfalls were appropriately addressed. People, their relatives and staff were regularly asked for their feedback about the service. They knew how to make a complaint and said more recently, any issues were properly addressed and resolved.

We found five 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.

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?

Requires improvement 

The service was not always safe.

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

Less visible areas of the home were not clean. Staff had received training but not all practices, promoted effective infection control.

There were shortfalls with the management of some people's medicines.

Staff had received updated safeguarding training and were aware of their responsibilities to recognise and report potential abuse. Recent abuse allegations had been properly managed.

People were protected by safe recruitment practices.

Is the service effective?

Requires improvement 

The service was not always effective.

Information in care plans did not show how people were supported to make choices or give consent to potential restrictive practices, such as bedrails.

People were supported by staff who felt well supported. Staff received a range of training to help them do their job effectively.

People had enough to eat and were complimentary about the meals provided.

People received good support from local GP surgeries and other agencies, to meet their health care needs.

Is the service caring?

Requires improvement 

The service was not always caring.

People were complimentary about the majority of staff but said the care sometimes varied according to who was on duty. Staff generally showed a caring, positive approach when interacting with people.

People's dignity was not always promoted. There were many positive interactions but also some, which could be improved upon.

Various social activities were arranged but some people in their bedrooms received limited interaction.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Some people were not given appropriate assistance to drink and fluid charts were inconsistently completed. These areas were addressed by the acting manager and improved as the inspection progressed.

Summary of findings

Care plans did not consistently reflect people's needs and the support they required. Work was being undertaken to make care plans more person centred.

People looked well supported and were generally happy with their care.

People and their relatives knew how to raise a concern. They felt listened to and issues were being more quickly resolved.

Is the service well-led?

Requires improvement 

The service was not always well led.

The registered manager was on leave. The previous deputy manager was managing the home on a day to day basis with regular support from senior managers.

Senior managers were aware that the home was not operating as they wanted it to but improvements were being made.

A comprehensive auditing system was in place to monitor and review the quality and safety of the service.

People, their relatives and staff were encouraged to give feedback about the service. Views were taken seriously and used to improve provision.

Avonmead Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced on 23 November and continued on 3 and 8 December 2015. The inspection was carried out by one inspector, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In order to gain people's views about the quality of the care and support being provided, we spoke with 14 people and 6 relatives. We spoke with 8 staff, the acting manager and two senior managers. We looked at people's care records and documentation in relation to the management of the service. This included staff training and recruitment records and quality auditing processes.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We asked the provider to complete 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. The PIR was received on time and fully completed.

Requires improvement

Is the service safe?

Our findings

Prior to the inspection, allegations of abuse and neglect had been made in relation to three members of staff. Appropriate action was taken and the staff members were suspended, pending investigation. Senior managers worked closely with the local safeguarding team and the police. At the time of the inspection, the investigations were in their final stages. The members of staff remained on suspension and their positions were being covered by existing or agency staff.

At the time of the allegations, people's safety was compromised. However, actions taken and increased monitoring, minimised further risk to people. Three relatives confirmed this. One relative told us they had raised concerns about safety although these had been resolved. Another relative said "there have been a few issues but things are improving". One relative told us they had identified bruising on their family member's arm. They said they had reported this but knew their family member had frail skin so bruised easily. They said their concerns were appropriately addressed and as a result, they wanted no further action. The relative told us they were monitoring the situation and would report any other concerns, without delay.

The allegations of abuse and neglect had impacted on the service. Senior managers had met with people, their relatives and staff encouraging them to be extra vigilant and to raise any concerns they might have. However, due to the investigations taking place, specific, detailed information could not be shared. This caused some people, anxiety and apprehension. One person told us they were concerned about the attitude of one carer. They told us they had not told anyone because "it could make things worse". The person did not want to give us further detail. Senior managers were concerned about this. They said they would focus on ensuring people were given further opportunities to raise their concerns, without fear of reprisal. Staff told us the atmosphere of the home had recently improved and they were confident, there was a good team in place.

Following the allegations, all staff had been individually spoken to about safeguarding. The discussions included what constituted abuse, how it could be identified and staff's responsibility to immediately report any concerns. Staff showed they had a clear understanding of how to keep people safe. Records showed staff had received updated safeguarding training. Assessments were in place, which identified potential risks to people's safety. The information showed what action was being taken, to keep people safe. On the ground floor, there were records which informed staff about the correct settings for people's pressure relieving equipment. These were regularly checked to ensure they were correct. However, on the ground floor, this practice was not so consistent. The alarm on one mattress had been activated, indicating there was a problem. Staff had not identified this. Once brought to their attention, staff checked the mattress and it was on the wrong setting. Further monitoring indicated the mattress was faulty and it was replaced. It was brought to the staff's attention that this mattress was also on the wrong setting. Inconsistent monitoring of the pressure relieving mattresses, placed people at risk of pressure damage despite having the preventative equipment in place.

Other people told us they felt safe living at the home. One person told us "it is safe because there are some very kind people and there is a lot of humour around". Another person told us "the girls [staff] are kind and they make you feel safe here". Other comments were "I am confident things are safe and I can get help if I need" and "people are very kind and that makes me feel safe. I know that people are listening to me". One person told us they wanted staff to accompany them to a hospital appointment, as they felt safe with them. Other relatives were equally positive about their family member's safety. Specific comments included "when I go, I know X is safe because she is well looked after" and "it's just brilliant here. A very good set up. Safe and well looked after".

There were various comments about staff shortages. These included "we need more staff. That would help altogether", "staff shortages are a real problem" and "it depends on the time of day whether you have a wait or not. It's worse in the mornings". Other people told us they had to wait longer during the night or at weekends. One person told us "sometimes staff turn the bell off and say they'll be back, so that's another wait. It's not an extreme wait but it's long enough". Another person told us staff changed their incontinence aid whilst they remained in their armchair. They told us "if they had to take me to the bathroom, I'd need a hoist and that would require two staff so I would need to wait longer. It's easier to do it whilst I'm in the chair". A relative told us "staffing levels are rather low. Sometimes X has a 20 minute wait for the toilet. It can be

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Is the service safe?

distressing". Another relative told us delays were more noticeable at weekends. Records of a recent resident and relatives' meeting, showed concerns had been raised about staffing levels. On a particular day, a person's daily record stated "no time for full body wash".

One member of staff told us the staffing allocation was sufficient. Another staff member told us staffing levels were fine unless staff went sick. They said shifts were difficult to cover at short notice, so they often worked with less staff than preferred. Other staff were less positive about the number of staff available. One member of staff told us "we get allocated ten minutes per person, which isn't enough, taking into the dependency of many people here. If we were robots we could perhaps do it, but it's not enough to give a good service". Other comments were "we can do the basics but don't have a lot of time to do anything else" and "there isn't enough staff to give proper, individualised person centred care". Another member of staff was concerned about the amount of agency staff being used. They said it did not give people continuity, which was "not fair on them".

During the inspection, the home was hectic and call bells were ringing regularly. On the first floor, the registered nurse was serving mid-morning drinks to people. They told us they were aware, it was not the best use of their time but said it was essential to ensure everything got done. One person used their call bell, as they wanted assistance to use the bathroom. They were waiting five minutes after we had noted their call bell was ringing. The person told us waiting for staff was not an unusual occurrence.

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

Staffing rosters showed there were six care staff and two registered nurses or one registered nurse and a senior carer on duty during the day. Staff told us out of 33 people, 23 required the assistance of two members of staff to help with their personal care. They said staffing levels were insufficient to support these people effectively. Senior managers told us a dependency tool was used to determine staffing levels and at present, they felt staffing levels were satisfactory. They confirmed staff sickness was a problem, which was being addressed via better absence monitoring procedures. In addition, the deployment of staff was being reviewed. The deputy manager told us an audit of staff response times to call bells was regularly undertaken. Any concerns were being investigated and addressed with staff. Senior managers told us they wanted staffing levels to be appropriate to the needs of people. They said to ensure this, they had asked staff to give specific examples of any shortages and the impact this had on people. They said they would then review the information and address any issues appropriately.

There were some shortfalls with the administration of people's medicines. During the inspection, it was identified that one person did not have one of their medicines, as prescribed over a weekend period. Senior managers undertook an investigation as soon as this was brought to their attention. They formally spoke to a member of staff and contacted the agency who had supplied the nurse, who made the initial error. Some people were prescribed pain relief via patches, which were applied to their skin. Staff had not always applied these, using appropriate rotation. For example, they applied the patch without a sufficient gap between re-application to the same site. The removal of the patch was not always recorded. This presented a risk that the person could have more than their prescribed dose, as a result of the residual medication retained in the patch to be removed. Another person had pain relief prescribed as a regular dose, four times a day. The medicine was being given on an "as required" basis, which meant the person may have experienced pain, due to insufficient medicines.

Records did not consistently inform staff where, how often and in what quantity, topical creams and ointment were to be applied. Staff had not consistently signed the record to show they had applied people's topical creams. This did not enable maximum effectiveness or enable staff to monitor if the creams were effective, in managing the person's condition. There were protocols in place to enable staff to administer people's "as required" medicines, as prescribed. However, some protocols lacked detail. For example, one medicine had been prescribed to treat constipation. The protocol did not state how long the person should go without having a bowel action, before the "as required" medicine was given.

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each medicine administration record showed a clear name, date of birth, allergy profile and dated, up to date photograph. This minimised the risk of the medicines being

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Is the service safe?

given to the wrong person in error. Guidelines, signed by a GP described those "over the counter" medicines which could be given to people. There were pain assessment records, which assisted staff to identify if those people unable to verbalise, required pain relief.

Whilst acknowledging senior managers told us work had been given to cleanliness and good infection control practice, some shortfalls remained. Not all less visible areas were clean. There was debris on the beading of over-bed tables and on the table legs. The passenger lift was not clean and there were stains on some carpets. There was dust on electric fans and the light pull chords were stained brown. There was a strong odour in one area of the home. A bathroom had a damaged surface and some bumpers covering bed rails, were worn and could not be wiped clean. There were toiletries such as shower gel and a topical cream in one bathroom. These items should not be used communally due to the risk of infection. One person raised concern about the cleanliness of the home. They told us "it's the little things that let them down – just look in the corners".

This was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Effective recruitment procedures ensured people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people.

Requires improvement

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Information about consent to care and treatment in people's records was not easy to locate. This was predominantly because of the changes from an existing system to a newly introduced care planning format. Those care plans of people with cognitive impairment did not show staff how they should support people to make choices. The processes used to evidence consent and those people consulted with, were not clear. For example, many people had bed rails in place and whilst assessments identified potential risks, consent to their use, was not stated. Another record showed staff had "no reason to doubt" a person's capacity but the consent to photography record had been signed by the person's family member and a member of staff. This was not appropriate unless the person had authorised them to do this. Another record stated a person was "not safe in 'bucket chair' so stays in bed". There was no information about the processes followed to agree this practice.

Staff generally asked people for their consent when providing support. However, there were two occasions when staff asked people a question but did not wait for a response. They did not give sufficient time and as a result, did not respond effectively to people's impaired cognition.

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

Staff had a detailed introduction to the home when newly appointed. They shadowed a more experienced member of staff until they felt confident to work on their own. New nurses, who completed their training abroad, received a two week residential induction prior to commencing employment at the home. In addition, they received mentorship until their probationary period was completed.

Staff told us they felt well supported and were positive about the training they received. One member of staff told us "the training here is very good. There's lots of it and they keep you up to date. They let you know if you need any updates". Other comments were "the training's excellent, we do all sorts of things" and "we do the usual things like manual handling, infection control and safeguarding but also other things of interest". Staff told us they could ask for training to be provided in any area, they were not sure of. One member of staff told us whilst the training was good, they would like more courses related to older age. Another staff member told us they did not always find the computerised training, as useful as face to face courses. The acting manager told us they would take this into consideration when organising future training.

All training records were held electronically. There was a matrix which showed the training staff had completed and those courses which were scheduled. The system gave the acting manager an alert, if any training updates were required. Records showed staff were reminded and "chased" if they had not completed their training. The acting manager told us staff were given support to complete their training, if they found certain areas difficult. They said they would be focusing on different styles of training in the new year. This would include experiential training such as staff assisting each other to eat, so they could feel and reflect on how it made them feel.

The acting manager had developed a programme of formal staff supervision to ensure all sessions took place on a regular basis. Supervision was a system whereby staff met with their supervisor to discuss performance and any concerns they might have. Records showed during the most recent supervision session, safeguarding had been discussed with each staff member. Senior managers and the acting manager confirmed that whilst supervision was taking place, further time was required to fully embed the system. This included identifying potential shortfalls and agreeing action plans to ensure development. Staff told us they found supervision useful but also raised any issues at the time. This enabled issues to be quickly addressed without further escalation. There were some comments

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Is the service effective?

from staff that they would like to see some staff more robustly supervised whilst undertaking their work. Managers told us this had been discussed and greater monitoring was now in place.

People had confidence in the staff and thought they were well trained. One person told us they needed to use the hoist to move safely. They said staff were confident in this procedure, telling us "no accidents so far. Staff know what they're doing". Another person told us "staff know what they are doing and I've no complaints about my care". A relative told us staff were good at providing end of life care. They said "dad had very good end of life care here. They supported him and the family fully. They had a good understanding of end of life care and a high degree of skill".

Staff told us people's special dietary requirements and personal preferences were catered for. They said this included soft and pureed meals and any restrictions in food, related to specific health care conditions. Staff told us advice about allergens was available to ensure people with allergies were protected from harm. The chef was always informed of people's dietary needs and any conditions, which could affect their eating, before or on their admission to the home. The chef then met with people to discuss their preferences. Staff told us "our menu is tailored to what people want".

People told us they liked the meals provided and had enough to eat. One person told us "the food is very good here. If you don't like what is on the menu, chef will get you something". Another person told us "the food is very good. Plenty of it and very tasty". People told us if they wanted a snack or hot drink, they just needed to ask and staff would get it for them. Relatives were equally positive about the food provided. They told us "the food is pretty good. I come in every day to help X with her dinner" and "X has put on weight since being here. The food is good and is well presented".

The lunch time meal looked colourful and well presented. Meals were served according to preferred portion size. Bowls of fruit were available within communal areas so people could help themselves to what they wanted.

Speech and language therapists (SALT) had assessed those people at risk of choking and malnutrition. Some people had been prescribed thickener for their drinks. Information about the person's level of swallowing difficulty and the amount of thickener required was detailed in their care plan. People's weight was regularly monitored. Records showed one person had gained significant weight since their admission to the home. This was positive for them. Another person had lost weight but had been assessed by SALT and a dietician. The person was being assisted by staff at meal times in order to promote the amount eaten.

People told us they were able to see their GP when they wanted to. Records showed people had access to a range of health care services. This included chiropody, speech and language therapy and attendance at hospital appointments. Staff told us people received good support to meet their health care needs although there were occasional delays in GPs visiting. They said people were encouraged to remain registered with their previous GP, if at all possible. This ensured continuity of care and an increase in the person's confidence.

Requires improvement

Is the service caring?

Our findings

People's dignity was not always promoted. One member of staff was assisting a person to the bathroom to have a shower or bath. They transported the person along the corridor on a wheeled shower/commode chair. The person had a blanket over their legs but their nightwear was rucked up showing a bare lower back. The person was not wearing underwear. This compromised their dignity. Some staff spoke about people in terms of room numbers rather than using their name. One member of staff told another, "I'm just going to do Room X now, alright?" This did not show a person centred approach.

Within people's care plans, there was a document titled "My choices". The document provided a framework to show people's earlier lives, important events and personal preferences. The documents were largely uncompleted. Some records, which aimed to present information about people's preferences, were insufficiently detailed. For example, one record asked what the person liked to talk about in order to enhance conversation. Staff had recorded "anything". This did not inform staff about the person or their interests. Another record asked about important events. Staff had recorded "children" but there was no further information about the children's names or ages. A further record asked about the person's sleeping preferences. Staff had recorded "in bed".

There was some information about people's end of life wishes. However, many end of life care plans were in the preliminary stages. One registered nurse told us they felt staff needed more training to support them in this area and to start difficult conversations with people. The member of staff told us this had been raised as a training issue and was in the process of being addressed.

People told us the care provided at Avonmead Care Home was generally good. However, some people described the care as variable, depending on which members of staff were on duty at the time. One person told us "I used my call bell and all I got was, 'what do you want?'" Two relatives also confirmed the care was variable. They told us "some staff do above and beyond and some are not good". Another relative told us "the care depends on who is on duty". Senior managers told us they were aware of some staff who could be less friendly and were addressing these issues.

More positively, there were complimentary comments about other staff. These included "the girls here are very kind and caring", "the girls give good care. Very kind people. A lot of humour around" and "the girls are very kind. I am sure that if I wanted anything I could tell them". One person told us "I'm very happy here, I wouldn't want to go anywhere else". Another person said "the staff are very nice. I have a joke with them. They're very friendly and know what I'm like. We have a laugh and a joke". Another person told us "I can get up whenever I like, go to bed when I like. This is my home here". A relative told us "the care is amazing. X is always very clean and well-dressed when I come in to see them".

Care was largely undertaken discretely and in a sensitive manner. Staff generally spoke to people in a caring, respectful manner. There were engaged signs on people's doors, which staff used when delivering personal care. This ensured they were not interrupted and the person received their care in private. Staff generally greeted people and their relatives when passing them but this was not always consistent. Some staff did not engage or appear welcoming. One member of staff assisted a person to eat but did not make any conversation. They repeatedly placed food to the person's mouth without explaining what the food was or if anymore was required. Another member of staff was friendly in their manner and spoke to a person about what had been on the television over the weekend. The person was non-committal and said they were not particularly interested. The person told us they did not particularly like the programme but it was the channel staff put on for them. The person said they did not like to change it and said "at least they come in and talk to me knowing the programme is on". The person told us they felt socially isolated without this interaction.

Whilst there were some interactions which could be improved upon, others were more positive. This included one member of staff assisting a person to drink. They were attentive, took their time and asked the person if they were enjoying the drink. They encouraged the person to drink as much as they could by giving reassurance and encouragement. Another member of staff assisted a person to eat in a sensitive, caring manner. They repeatedly asked the person if they wanted another spoonful and waited until they had finished, before offering the next one. Another member of staff knocked on a person's door and called out when they entered. They were friendly and bent

Requires improvement

Is the service caring?

down to the person whilst stroking their arm. The person gave a big smile and was clearly pleased to see the staff member. The member of staff had a jovial manner which the person responded to well.

People told us there were social activities arranged, which they were able to join in with. One person said "I have been playing Travel Scrabble this morning. X is so good at organising things for us to do. We really miss her at weekends". Another person told us "they do ask me if I want to join in with things but I'm happy and don't want to". Staff told us one-to-one activities were provided for people who were unable or preferred not to leave their bedroom. The acting manager told us they tried to ensure these people received appropriate stimulation. This included hand massages or manicures. A senior manager told us of the home's guinea pigs being used as a therapeutic activity to promote relaxation. Whilst we were told about these activities, we did not see very much interaction with people in their bedrooms unless tasks were being completed. The acting manager told us they would discuss the development of social interaction and activities with people and the staff team.

Requires improvement

Is the service responsive?

Our findings

There were concerns about some people's care. One person told us they were used to having a regular shower but they only had one a week, in the home. They told us "I have asked if I can have more but the staff tell me they are stretched and very busy". A relative told us "[my family member] spends most of their time in bed and usually lives in their night clothes. On one occasion, they were in the same clothes for three days. I complained and things were done. Things are much better now". Another relative told us "I look in my [family member's] care plans and nothing is recorded at night so I don't know if she has had a drink from 8pm to 8am. I always give her a drink when I come in. She has had a number of urinary tract infections. I have raised the matter".

Staff were not fully attentive to people's needs. At 2.45pm on the first day of our inspection, one person was in bed. They looked dishevelled and their bottom sheet had come away from their mattress. There was untouched cake and a drink on their over-bed table and food debris and a pillow on the floor. At 2.50pm, a member of staff offered the person assistance but it was not clear how long they had been in the dishevelled state. At 3.55, the cake and drink remained on the person's table untouched. Nothing had been written in the person's daily records in relation to the care they had received during the day.

On the first day of our inspection, those people requiring assistance to drink were not fully supported. Some people had tea or coffee in front of them which had gone cold. One person had an orange coloured drink, which contained thickener. Due to the length of time in place, the drink had solidified and there was a spoon standing in it. The drink was not consumable but had not been removed. People had a jug of juice and a glass next to them. The amount of fluid within the jugs did not decrease as the day went on. Staff told us the registered nurse served people their mid-morning and mid-afternoon drinks. They said care staff then supported those people who required assistance. Whilst acknowledging this, due to the number of drinks left untouched, the system did not appear to work well. On the second day of the inspection, the acting manager told us they had addressed the shortfalls with the staff. This was evidenced, as people were more readily supported, throughout the remainder of the inspection.

There were charts in place which staff completed to show what food and fluid some people consumed. The charts were inconsistently completed. The person's recommended daily intake was not stated and the daily amounts were not always totalled. This showed staff were not effectively monitoring people's fluid intake. One record showed a person's first drink was at 12.40pm. The majority of charts showed people did not receive regular drinks during the evening. Later in the inspection, the completion of the fluid charts had improved.

Staff signed care charts to show they had provided people with personal care. The records showed "toilet care" had been given but the times of this, were not stated. This did not enable staff to be clear of the last time people received support and when they needed further assistance. Some records showed people had been supported to change their position to minimise their risk of pressure damage. However, some people remained in the same position, whilst in bed. Staff told us this was because some people were "tilted" rather than "turned" so they appeared to be in similar positions. People's records did not reflect this practice. At 11.30am on the first day of our inspection, there were no entries to state one person had received personal care.

Whilst care charts were not fully completed, people looked well supported. Other than the one person who looked dishevelled, people had clean clothing or nightwear and freshly brushed hair. People's nails were manicured. Those people in bed had clean bedding, comfortable bedding.

Care plans did not always reflect factors related to their condition. For example, records of those people who were prescribed warfarin, informed staff of the need to check for bruising. The records did not detail how bruising or bleeding might be minimised. This included gentle moving and handling and careful application of hoist slings. Similarly there was nothing about minimising the complications of skin tears where people were prescribed long term steroid therapy. One person had very contracted hands. There was no information in their care plan, to inform staff how to care for their hands to prevent soreness and infection.

Care plans were not always easy to follow. Some entries stated "ensure staff are aware of X's needs" but it was not clear how this was being undertaken. One care plan identified the treatment a person had received to manage a wound. A treatment plan, which was to be followed,

Requires improvement

Is the service responsive?

monitored and reviewed, was not in place. There was not a series of photographs to monitor the progress or deterioration of the wound. Much of the information within care plans showed how people were to be supported with their basic activities of daily living. There was little information about the person as an individual.

Whilst there were shortfalls in the care planning information, staff were aware of people's needs. Staff told us about the support some people required, including their personal preferences, likes and dislikes. Staff's knowledge about people was not always identified in care documentation. The acting manager told us they were hoping this would be addressed during the implementation of the new care planning format.

This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they knew how to make a complaint. They said they would tell a member of staff or the acting manager if they were not happy with the service they received. They said more lately, the complaints process had become more robust and concerns were being listened to and responded to quickly. However, some people told us they did not want to complain because they thought there might be 'come-backs'. The acting manager told us they were seeking to reassure people that their concerns would be listened to and acted on. One person told us they had recently had a meeting about their care. They said this was also an opportunity to raise any concerns they had. The person told us "if I need to chat to someone about anything, I see the one in charge and they will always chat to you". Copies of the complaints procedure were prominently displayed around the home.

Requires improvement

Is the service well-led?

Our findings

The registered manager was on leave. In the absence of the registered manager, the home was being managed on a day to day basis by the previous deputy manager. Senior managers were regularly visiting to provide additional support and to manage certain areas, such as human resources. Senior managers told us the deputy manager was doing extremely well in their new role of acting manager. They said the management team recognised the home had not been effectively managed and were ensuring "a clean sweep". Senior managers told us the home was not functioning as they wanted it to. They said they were looking to conclude all investigations in relation to the abuse and neglect allegations. Once completed, they said clear focus would be given to "moving the home on".

The acting manager told us they were building relationships with people, their relatives and staff. They said they wanted people to be open and raise any issues, they might have. To assist with this, the acting manager told us they spent the majority of each morning, "on the floor" talking to people and their relatives. In addition, the acting manager told us they talked to staff, assisted where required and observed staff practice. They said this enabled any issues to be identified and addressed at an early stage.

The acting manager told us their role had been a learning curve but they were receiving good support from senior managers and the staff team. They said their aim was to ensure people received a good standard of care and in time, they would be striving for excellence. Staff were very complimentary about the acting manager. One member of staff told us "she's been good for the home. She's resident focused and takes time to listen. She knows people really well and knows the routines so that helps". Another staff member told us "we all know we can go to her if we need to. She's very supportive and wants what's best for people. She's very approachable". People and their relatives told us the acting manager had a visible presence so they knew her well. They said and the acting manager was "open", "approachable" and "responsive".

There was a comprehensive system to monitor the quality of the service. The format of each audit was held electronically and gave clear guidance about what was to be assessed. This included a daily 'walk around' audit, which involved checking a required amount of care records, certain infection control issues and talking to a range of people and staff. If any aspect of the audit was not filled in, the system would not allow the audit to be completed. The acting manager told us if any shortfalls were identified, the system would prompt a required action. These actions would remain 'open' electronically until fully addressed. This ensured any issues were always acted upon and things did not get missed. The acting manager told us alerts identifying shortfalls, were automatically sent to various senior managers. This gave added monitoring, to ensure the development of the service. The audits were undertaken on a hand held device, to increase efficiency.

There were other audits, which were completed by departments. This included the maintenance staff undertaking environmental checks. Records showed window restrictors and wheelchairs were regularly checked to ensure they remained 'fit for purpose'. The hot water was monitored to minimise the risk of very hot or unpredictable hot water, which placed people at risk of scalding. As a result of the audits, senior managers told us a lot of work had been done to improve the environment for people. This included improved cleanliness, infection control practice and redecoration of corridors and some people's bedrooms.

Within the entrance hall, there was an electronic system which encouraged people, their relatives and staff to give their views about the service. The system enabled people to request a call or a meeting with the acting manager if required. Any negative comments were automatically sent to management for them to respond. The acting manager told us the electronic system was relatively new but had received a good response. In addition to this system, surveys were used to request feedback about the service. The acting manager told us the majority of feedback was raised on an informal basis through general conversation. They said regular 'residents and relatives' meetings were held to share information and to encourage ideas. People told us they felt their voice was heard and their opinions were listened to. Records of the meetings were posted on the notice board in the entrance area of the home. This enabled people to see their views were taken seriously and acted on. The acting manager told us minutes of the meetings were sent to those relatives who were unable to attend.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The deployment of staff did not enable people to be supported effectively. There were many comments about staff shortages and some people were kept waiting for assistance. Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **There were some shortfalls in the management of people's medicines. This included one person missing their medicines, topical creams not being applied as prescribed and insufficient rotation of pain relief patches. Regulation 12(2)(g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Less visible areas of the home were not clean and there were shortfalls in practice which did not promote good infection control principles. Regulation 12(2)(h).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Records did not show how those people with cognitive impairment were assisted to make choices. Consent to potential restrictive practices, such as bed rails was not clear and did not demonstrate due processes had been followed. Regulation 11(1).**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Not all people were sufficiently supported to drink effective amounts. Records were not consistently completed to evidence the care people received. Care plans were not person centred and did not fully reflect people's needs and the support they required. Regulation 12(1)(2)(a)(b).