Bupa Care Homes (BNH) Limited

Ardenlea Court Care Home

Inspection report

Bucknell Close
39-41 Lode Lane
Solihull
West Midlands
B91 2AF

Tel: 01216672853
Website: www.bupa.co.uk

Date of inspection visit:
17 May 2017
19 May 2017

Date of publication:
27 June 2017

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**

Summary of findings

Overall summary

This inspection took place on 17 and 19 May 2017. The first day of our visit was unannounced; however we informed the manager we were returning on 19 May 2017.

Ardenlea Court is a nursing home which provides nursing care to people with physical disabilities and people who live with dementia. The ground floor provides a permanent residency to eight people, and an Intermediate Care Unit (ICU) comprising of 18 beds. The ICU provides beds contracted by the NHS for people who are ready to leave hospital but require further assessment to determine their longer term needs. These are termed 'discharge to assessment' beds.

The first floor provides a maximum of 29 beds for people who live with dementia. On the day of our visit there were 50 of the 55 beds occupied.

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.

At our last visit we had rated the home as 'Good' overall and 'requires improvement' in 'Responsive'. During this visit we found the quality of the service had slipped and the rating was now 'Requires Improvement' overall. We found however, that the organisation was aware of most of the concerns found at this inspection, and had already started to take steps to improve the service.

The registered manager had to take an unexpected leave of absence which lasted a few months. They had recently returned and were being supported by a regional support manager to improve the service after internal management checks found the service was not meeting the organisation's internal compliance standards.

A combination of staff deployment and/or insufficient staff meant nursing staff on the ground floor were not able to meet people's needs safely, and staff working in the dementia unit, were not able to support people's independence, social and emotional needs well.

Prior to our visit, the home's medicine management had been audited by an external pharmacy technician. They found concerns in the home's management of medicines. During our visit we found further concerns. Risks related to people's health and well-being were not always fully or accurately assessed.

As was identified at our previous inspection, people who lived at the home on a permanent basis, continued to not have enough support to take part in individual or group activities, or activities that reflected their needs and wants.

Staff understood the Mental Capacity Act, and Deprivation of Liberty Safeguards (DoLs) had been applied for where people's liberty was restricted. Most people's capacity to make decisions had been assessed.

The menu for the home offered people a choice of meal each day. However, care practice meant that people who lived with dementia were not offered a choice in a way they could understand. The home catered for people with specific diets and nutritional needs.

Staff had received sufficient training to support people's health and safety. Nurses received training to support them in clinical practice and to maintain their nursing registration. Staff did not receive sufficient training to support practice at the home being classed as 'specialist dementia care'.

Checks were carried out prior to staff working at the home to reduce the risk of employing staff unsuitable to work at Ardenlea Court. Staff understood their roles and responsibilities to keep people safe.

Premises and equipment were safe for people to use. The dementia unit had recently been redecorated and provided a nicer environment for people who lived with dementia.

Most staff were caring and kind and treated people with dignity and respect. Staff felt the registered manager was approachable and open to their suggestions and ideas.

Visitors were welcome at the home. The manager was available to people and their relations if they had any concerns about the care provided. Complaints were taken seriously and fully investigated.

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

The 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 enough staff deployed in the intermediate care unit to assure people's safety, and staff deployment in the dementia unit meant people's freedom and independence was at times restricted. Medicines were not always safely managed, and risk assessments were not always accurate.

Staff knew their responsibilities to keep people safe from harm. Recruitment practice reduced the risk of the service employing unsuitable staff. Premises and equipment were well maintained and safe to use.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training and support to meet people's health and safety needs, but they had not received training to provide 'specialist dementia care'. Deprivation of Liberty Safeguards, were in place where people's freedom had been deprived, but some people's capacity to make decisions had not been assessed.

There was a choice of meals, but people with dementia were not offered choice in a way they could understand. People's nutritional needs were met, as were their healthcare needs.

Is the service caring?

Requires Improvement

The service was mostly caring.

We saw staff being kind and caring to people, although we were told of instances where this was not the case. Care provided was task focused and did not meet the needs of the person as a whole. People were not involved in their care planning. Visitors were welcomed in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

As was identified at our last inspection, people's emotional and social needs continued to not be sufficiently responded to. Staff did not always respond appropriately to people's needs, and care records were not always accurate to support staff in their responses to people. Concerns were acted on, and complaints investigated in line with BUPA's complaint policy and procedure.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

Areas identified as requiring improvement at our last visit had not been improved. The registered manager had to unexpectedly take leave of absence from the service for a few months, and during this time internal compliance checks had identified shortfalls in the quality of the service. These were being addressed by the regional support manager and the registered manager on their return to work. Staff felt the registered manager was supportive, open and transparent.

Ardenlea Court 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.

The inspection took place on 17 and 19 May 2017. It was unannounced on 17 May 2017, but the registered manager was made aware we would be returning on 19 May 2017 to complete our visit.

The inspection team consisted of two inspectors 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. Our expert by experience had experience of older people and dementia care.

Prior to our visit we gathered and reviewed information about the service. This included statutory notifications and the provider information return (PIR) which was sent to us on 30 April 2017. A statutory notification is information about important events, which the provider is required to send to us by law. The PIR is a pre-inspection questionnaire completed by the provider which provides us with a 'snap-shot' of the service.

During our visit, we spent time in the communal lounges and dining areas to see how staff engaged with people who lived at the home. With people's permission, we also spoke with people in their own bedrooms.

Most of the people who lived in the dementia unit were not able to tell us in detail about how they were cared for and supported because of their complex needs. We used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During our visit we spoke with 10 people and 11 friends and relatives. We spoke with 13 staff including nursing, care staff, maintenance, the chef, activity worker and receptionist. We also spoke with a physiotherapist, a pharmacist, a pharmacy technician, the registered manager and regional support

manager.

We contacted commissioners of the service to find out their views of the service provided.

We reviewed seven people's care plans and daily records to see how care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We checked medicine records, complaints, and the provider's own checks to ensure the service operated safely and effectively to provide quality care to people.

Requires Improvement

Is the service safe?

Our findings

One of our inspection team spent a significant amount of time on the ground floor looking at how people in the ICU who were using the 'discharge to assessment' beds, and people who lived permanently on the ground floor of the home were supported. The discharge to assessment beds were for people who were well enough to be discharged from hospital but continued to require nursing intervention and assessment to determine the next course of action to meet their physical, social and emotional care needs. Staffing levels and staff deployment did not always ensure people's individual needs were met.

During our time on the unit, we found nursing staff were very busy, and the unit was at times disorganised with nursing staff appearing overwhelmed. We saw nurses found it difficult to complete a task without being called away to deal with a new or different situation. We were concerned people were at risk because nurses did not have enough time to undertake their duties systematically and safely.

Nursing staff informed us of the challenges they had in providing the discharge to assessment service. They explained because people on the discharge to assessment scheme would normally only stay at the home for a maximum of six weeks, there was a lot more paperwork which needed to be completed when people arrived, and the same again when people were discharged. One nurse told us, "The volume of work is horrendous…it's really hard and there is a high turnover of people. I feel I am always juggling all the time, we're supposed to monitor people's records but don't always have time." Another said, "It wears you down, I never leave on time and I am so stressed, nurses are leaving because of it." The regional support manager told us whilst three members of staff had recently left the service, none had said it was because of stress.

The notifications the provider sent to us about the number of deaths in the unit confirmed the information provided by staff. For a home the size of Ardenlea Court, the number of deaths was more than double that expected. This reflected the amount of palliative care provided to people. We were told by a member of staff by the time the funding had been agreed for a person to move out of hospital and into the unit; they often had a matter of days to live. They told us this added to the pressure placed on nursing staff because once a bed became empty there was pressure to fill it straight away. The regional support manager informed us this was because when a bed became empty the NHS teams involved in the contract for the bed would then look to see which patients in hospital would fulfil the criteria for admission.

Each Tuesday, nursing staff in the ICU supported a GP on their 'ward round' and each Wednesday they were involved in a MDT (multi-disciplinary team of healthcare professionals) meeting. Whilst the nursing staff were supportive of both these initiatives, they found this led to additional pressure on their time. We spoke with the registered manager and a senior manager from BUPA about our concerns. They had already arranged a meeting with nursing staff the following week, and we asked they discuss the concerns raised by nurses at the meeting. After the meeting they contacted us to confirm they were recruiting for a position of 'ward clerk' and they hoped this would take some of the pressure off the nursing staff. In the interim, a care worker had agreed to take on this responsibility.

We found there were enough care staff on the ground floor to keep people safe, but we were concerned

about the level of, or deployment of care staff on the first floor dementia unit. During the first day of our visit, one of our inspectors spent the day engaging with staff and people on this unit. We found staff had been deployed in the communal areas of the unit to supervise people to make sure they were safe from harm (for example, from falling). One relative told us, "My wife now living here is better in so many ways. They can constantly monitor her here; she fell down the stairs twice while she was at home with me."

However, we saw in both the lounge and communal dining room people who required assistance, were discouraged from walking around, either through staff telling them to sit back down, or, in one instance, a member of staff continually holding a person's arm to stop them from getting up from the dining table. Whilst we could see that staff did not want people to harm themselves or others, they were restricting people's freedom of movement as there were no other staff available to support them when they moved away from the communal area. At lunchtime we found staff deployment did not support people who needed encouragement and time to eat their meals. People were left with their meals in front of them with no staff available to encourage them to eat.

We discussed our concerns and observations with the management of the home. They felt there were enough staff available to support people's needs on the first floor, but said they felt they could manage the deployment of staff more effectively.

The service had gone through a period of higher than usual staff absences due to staff sickness, and staff told us this impacted on the care provided. This was because sometimes the absences could not be covered by permanent staff and agency staff (staff employed by an agency to work in care settings which require additional staff) were then required to support people with their needs. This meant people were not always supported by staff who were familiar with their care needs. The regional support manager told us they had started to address this issue through more effective use of the BUPA sick leave policy. They hoped this would have a beneficial effect on stress levels of staff who covered for those on sick leave, and also would mean greater continuity of care for people with reduced levels of agency workers.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014, Staffing.

We checked if people's medicines were managed safely and found concerns. Prior to us checking medicines, the manager informed us they had recently been audited by the pharmacy technician and the audit had shown there to be a number of shortfalls in medicine management. They were working to improve their management of medicines.

The Solihull hospital pharmacist and pharmacy technician have an agreement with the commissioners of the ICU to oversee medicine management in the home. They contacted us during our inspection visits to inform us of their findings. These included concerns about the records for receiving medicines into the home and alterations on medicine records but with no explanations. They had concerns about what they described as poor register entries for disposal of stronger medicines, and for when medicines left the premises. They had also noted that some people had not received their medicines as prescribed. Some of these were strong medicines to reduce people's levels of pain.

On the second day of our visit the pharmacy technician and the pharmacist was at the home and showed us further concerns. They had found that a person who had been at the home for three days had received 25mg less of a prescribed pain relieving drug. The person had also received it three times a day instead of the twice a day as prescribed.

We found 'as required' (PRN) medicine plans were not always in place and when they were, they lacked detail as to why medicines had been given. The record simply said, 'in pain'. We found no pain assessments to determine the level of pain people experienced to help staff provide pain relief to meet the person's needs. For example, one person who received end of life care was on medicines prescribed for a person's end of life. The person was described as moaning in pain when they were turned in their bed. The person had regular paracetamol and codeine but the effectiveness of the pain relief had not been monitored.

We found when people came into the ICU on 'discharge to assess' beds, the home did not at times have accurate information about people's medication when they arrived. This meant there was more potential for staff to make mistakes when administering medicines. The registered manager informed us they were discussing this with the pharmacist to improve medicine records on arrival.

Prescribed creams had not been dated on opening and this meant we could not check whether they continued to be safe to use. Care staff were not consistently recording they were being administered which meant we did not know if they were administered when they should be. We found the eight medicine administration charts we looked at had been properly completed, and the records showing the amount of stronger medicines administered were correct.

People who lived in Ardenlea Court were assessed by staff to determine whether they might be at risk of harming or injuring themselves. This might be because, for example, they were unsteady on their feet and at risk of falling, or at risk of choking because they had swallowing difficulties. We looked at the 'risk assessments' to see whether they clearly identified potential hazards and how staff should respond. We found risk assessments did not always provide the detail required to support staff's knowledge about the person's risks; and in two cases, where people had been admitted five days prior to our visit, no assessments had been recorded. One of the two people concerned was at high risk of falls, and had been in hospital prior to coming to Ardenlea Court because they had fractured their neck as a consequence of a fall. Once identified to management, they rectified this immediately.

There were no risk assessments in relation to people who received medicines to thin their blood. This is important to ensure staff understood the potential side effects or complications resulting in taking such medicine. For example, people on blood thinning medicines are more prone to bruising.

We found one person was being nursed in 'isolation' to reduce the risk of spreading a hospital acquired infection. The door to their room was kept open, and visitors were not informed of the potential risk to themselves and to the person if they went into the room. We informed the registered manager of this, and they assured us they would take steps to ensure people did not go into the room without consulting staff first.

The service provided people with equipment to support their safety. For example, where people needed equipment to help them move or reposition in bed, or move from a bed to a wheelchair, there were enough slide sheets and hoists and individual slings for people's use. A relative told us, "The home is very clean and there's a good range of equipment." However shortly following our visit a concern was raised by a health professional about hoist slings not always being clean and the potential that the wrong sling size would be used. The health professional had reported this as an incident.

People who needed equipment to reduce the pressure on their skin, such as air flow mattresses and cushions had been provided with these. However, during our visit one person told us their mattress had deflated at 1.30am and had made the bed really uncomfortable. We asked the manager to check this for us, and on investigation they found the mattress had been set at the wrong setting. In response to this the

manager added to the monthly 'Home Improvement Plan' to discuss with nurses about the mattress settings to ensure they were aware of the correct setting for each person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014, Safe care and treatment.

Where possible, people administered their own medicines. One person told us they managed their own medication, and had been assessed by the pharmacist to do so. They felt their medicines were kept safe and accessible because they had a locked cupboard in their room which they had the key to.

The home was well maintained and any maintenance issues were dealt with quickly. We found the maintenance worker undertook periodic safety checks of water, fire equipment, and electrical equipment in line with safety guidance. Carbon monoxide levels were also monitored. The monthly home review undertaken by a senior manager identified that fire drills were out of date. This was being addressed.

The provider undertook monthly reviews of accidents, incidents and pressure sores. Where incidents had occurred, these had been investigated and action taken to reduce the risk of them happening again.

People were safe and protected from the risks of abuse because staff understood their responsibilities and the actions they should take if they had any concerns about people's safety. For example, one member of staff told us, "Abuse could be ignoring someone, talking badly to them or being emotionally abusive. I know I could tell the CQC." And another said, "It could be someone not having their pads (incontinence) changed when needed or someone swearing, I would tell the manager, they tell the local safeguarding team."

The registered manager understood the actions required of them, and notified the local authority if they had concerns a person had been abused. They also notified the Care Quality Commission if a referral had been made to safeguard people.

Most staff were aware of the importance of informing senior members of the organisation or external authorities if they felt the registered manager had not taken their safeguarding responsibilities seriously. However, two staff we spoke with did not know what they could do if they were not happy with the action taken by management. The provider had systems to support staff to 'blow the whistle.' They had a whistle blowing policy called 'speak up' with a dedicated staff telephone number advertised on the intranet and on posters within the home.

Staff recruitment procedures ensured all relevant checks were carried out to protect people from potentially unsafe or unsuitable staff. We looked at the recruitment records of two staff, and spoke with staff about their recruitment experience. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to work alone until the recruitment checks had been completed. The provider also carried out their legal duties by checking staff had the right to work in the UK.

Requires Improvement

Is the service effective?

Our findings

Most people and relatives felt staff had received the training they needed to undertake their work effectively. One person said, "A couple of nurses here do my dressings. They are top of the range and they really know their stuff." However, the same person went on to tell us that some care staff did not have a good knowledge or techniques when they transferred them from a wheelchair into their bed. They said, "Some have very haphazard ways." We looked at the staff training for moving people. We found all staff had received this training.

Staff who worked on both floors of the home felt they had received the right training to support them in their work. Staff had all undertaken training the provider considered 'mandatory' to support people's health and safety. Two of the nursing staff had recently completed the Gold Standard Framework training to support them with good practice when delivering end of life care; and all staff worked closely with the McMillan (cancer) nurses who came to the home.

Whilst staff had received training to meet people's health and safety, staff had not received training to provide effective and specialist dementia care. For example, one member of staff berated a person with dementia for using their fingers when eating. They said sharply, "Don't use your fingers, sit down and I'll help you." They did not appear to be aware that this was something that could happen with people who lived with dementia, and the focus was to make sure the person ate, rather than how they ate.

The provider's website informs people there were 'specialist dementia staff' who worked at the home. The nurses who worked on the dementia unit were trained mental health nurses and the care staff who supported them had basic dementia care training, but neither group were specialist trained in dementia care. We found through spending significant time in the communal areas of the home and seeing how staff engaged with people, the dementia care unit provided a 'contained' environment for people as opposed to one which provided people who lived with dementia the opportunities to maximise their life.

The management of the service recognised staff had not received sufficient dementia care training to support them in their work. They had already put plans in place for all staff to undertake training by Admiral Nurses (registered nurses with experience in dementia care who work collaboratively with families and with other dementia care providers, sharing their expertise and giving them the support and skills they need to be effective) to support them in improving their skills and knowledge of dementia care.

We checked that nursing staff received sufficient training and opportunities for developing new skills to retain their professional nursing status. We found the provider had supported them with their nursing 'validation'.

New care staff received one week's in-house BUPA induction training. This was linked to the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The week's training was provided by the BUPA trainer, and thereafter staff were provided

with a work book which detailed different competency expectations. The member of staff went through the work book, and once they had achieved competency in their roles, this would be signed off by their manager.

Staff told us they received support from senior staff and they worked well as a team. We were aware, because the registered manager had not been present in the home for a few months that individual supervision meetings had not been held regularly with staff. The manager said this was getting back 'on track'. A relatively new member of staff told us they felt they had been supported a lot because they were new to care work, and had been given guidance throughout their early days of working at the home.

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 care records in the dementia unit had identified where people had capacity to make decisions and when decisions had to be taken in the person's best interest. However, one person's record said the person lacked capacity to make decisions, and we found on the day of our visit, the person was very able to understand what we were asking, and responded with clarity to our questions. Two people recently admitted to the home on the ground floor, had not had their capacity to make decisions assessed. However for one, a DoLS had been applied for, which suggested they did not have capacity and further assessments should have been made.

The service had a DoLS tracker in place to show the applications they had made and whether an application had been granted by the supervisory body. It also noted when the DoLS would expire to ensure further applications were submitted. This made sure the service was undertaking its legal duties under the Mental Capacity Act.

Staff had received training to understand the MCA and DoLS. Comments made were, "Some people lack capacity so we may need to make simple decisions, for example, giving someone a shower." And, "We find out who has a DoLS in place and sometimes we have to make some decisions for people, major decisions would involve the family and social worker and doctors." All staff said they would leave someone who declined care alone and would try again later as they knew they could not force people to do something against their will. One staff member said, "I leave someone for a few minutes and try again but people have choice."

We asked people what their views were about the meals provided to them, and we saw how people who could not communicate their views responded when provided their meals. We found people were asked their meal preferences the day before the meal was served. The regional support manager told us this was because food was cooked freshly on the premises and the cook liked to know the evening before the meal was served to give them a rough estimate of quantities. They went on to say that people could change their mind about their meal on the day it was served. At our last inspection people were provided with choice,

and they spoke positively about the food provided. During this inspection we found people who lived with dementia were not provided with a choice.

We spent time in the dementia unit's dining room to gain insight into the lunchtime experience for people. We did not see this as positive. People with dementia were not offered a choice of meals, and some were sat in the dining room for 30 minutes before their meal was served to them. Staff took meals to people who ate in their bedrooms, at the same time as serving meals to those in the dining room. This meant there were not enough staff in the dining room to support those people who needed help with their meals, or to make sure they received their meals in a timely way.

For example, we saw one member of staff focus their attention on supporting one person with their meal whilst at the same table another person was sat with their meal for 25 minutes, and was only prompted once without success. It also meant staff could not support people whose behaviour could challenge others and meant the mealtime experience was not an enjoyable one.

We discussed this with the management team on the first day of our visit. When we went back for the second day, we were asked to look at the meal time experience again. We found this had improved. Non-care staff had been asked to be involved in supporting care staff with meals, and people who had their meals in the dining room were provided these at a different time to those in their bedrooms. This meant there were more staff available to both groups of people.

We also spent time gaining insight of the meal time experience on the ground floor. We found this ran smoothly and people received their meals in a timely way.

The chef had a list of people's menus choices which stated if they were on a specific diet such as a pureed diet. Staff were knowledgeable about people's dietary needs. We found where people were at risk of poor nutrition intake, their weight was monitored and referrals made to the appropriate healthcare professionals. A relation told us, "They are monitoring my wife's weight. She is eating well this month."

The chef attended a meeting every morning with the registered manager for updates on people's needs and the community diabetic nurse liaised with the chef about specific needs. Food was fortified with extra calories for those whose weight had reduced. Food and fluid charts were in place but there were no target fluid amounts recorded, this meant staff would not know how much fluid to aim to support the person to drink in a day to maintain their health. One person was on a pureed diet and became bored with the menu, and so staff worked with their relation to create the person's own menu.

People received healthcare when required. From looking at people's care records, speaking with people and their relatives we found that contact was made with various healthcare professionals to ensure people's healthcare needs were supported.

Requires Improvement

Is the service caring?

Our findings

Staff were mostly kind and caring. One person told us, "I'm absolutely 100% happy with the care," and another told us, "The carers are lovely." Whereas other people said, "I had a bit of an upset with one carer. I wanted the toilet but she said sharply "You'll have to wait". The others consoled me, they said she doesn't mean it;" and, "Someone [care worker] snapped at me the other day saying "It's more important to get the food out than to give you your painkillers."

A relative of a person on the ground floor said, "On the whole the care is quite good but there are not enough staff to care for everybody…They can be too busy, I needed a carer to help me move [my relation] from the bed to the wheelchair. [The care worker] said they had three others to care for and they couldn't come." A relative of a person on the first floor said, "The care is fine, I don't see much of the staff, but they seem fine." And another from the first floor said, "From what I see (the care) is always very good…I feel she gets the care she needs." A relative told us of reception staff, "The girls on the front desk are so welcoming [name of staff] is wonderful. She takes great care."

During our inspection we saw staff being kind and caring, but not always fully engaged with the people they supported. The majority of interactions with people was when staff fulfilled care tasks. During this time, staff were kind and attentive, and explained what they were doing. For example, we saw one staff member gently talk to a person who lived with dementia, who was agitated. They explained they were going to support them back to their room. They took hold of the person's hand and asked if they could walk with them and took several minutes calming the person who responded well.

However, for much of the time, people were not provided with support that enhanced their feelings of belonging or demonstrated they mattered. This was particularly so in the dementia unit. There was always a member of staff present in the communal areas to keep people safe. However, their engagement with people was often minimal. This was because they used this time to write their notes. Staff would respond to people, but would not always look up from writing their notes unless they needed to support someone with safety. A recent internal management report identified that the care on the dementia unit was 'task focused'.

We saw people being provided with drinks. During this time, we saw people supported to have their drinks, but this was not always at the person's own pace. We saw a member of staff stand over a person whilst they supported the person to drink, instead of sitting down with the person and using this as an opportunity for engagement. The person was aided to drink their drink very quickly. For those who did not need support, they had nowhere to put their drinks down as there were no side tables for people to use. At lunchtime, we saw staff focused on supporting one individual to eat their meal, but did not use this as an opportunity to engage with others sitting on the same table.

People on the dementia unit were not as independent as they wanted to be. This was because those who wanted to walk around, but who were at risk from doing so, were not always supported to walk because there were not enough staff available to help them.

Staff we spoke with had a caring approach to their work. They knew the needs of people who lived at the home, but they felt they did not always have the time to fully meet those needs in a person centred way. Some of the staff on the dementia unit on the day of our visit were not familiar with the unit and had not been trained to provide support to people with dementia. This impacted on their ability to provide good dementia care.

People were not always involved in making decisions or planning their own care. Care records showed limited involvement of people in their care planning, and the management team were aware of this. They had started to make improvements by reviewing people's care plans, and by re-instating the 'resident of the day' initiative (this is where, each day in the month, an individual resident's needs are checked to make sure the care is planned according to their needs and wants).

Whilst staff understood the importance of confidentiality, we saw on the ground floor that some confidential information was left unattended at the nurses' station when they were called away to undertake a nursing duty. This was discussed with the home's management who responded to this and other concerns on the ground floor by planning to employ a ward clerk who would manage the desk and ensure confidential information was not left out.

Staff we spoke with loved their work. They told us it could be demanding and very busy, but they enjoyed working with people who lived at Ardenlea Court. One member of staff told us, "I do think people get good care here." Other staff commented, "I love it here, I think it's a really homely atmosphere, you can feel the warmth." And, "They are like my family, you feel like you are at home, not at work." And, "I get very fond of people."

Staff were aware to promote privacy and dignity when providing personal care to people. Staff knew to make sure doors and curtains were shut so people were not exposed. Staff told us, "I always ask people if it's OK when I am undressing them. I want to make sure I respect their privacy." And, "I will give the person a flannel to wash their intimate areas; we also want to encourage their independence." And, "I always close doors and curtains to ensure privacy." We saw doors being shut prior to staff providing personal care to people, and we saw staff knock and wait for permission before they entered people's rooms.

Friends and relatives were made welcome at the home and there was no restriction on visiting times or the length of time they could stay with the person. Relatives sometimes supported their loved ones by helping them to eat and drink. One relative told us their relation needed one to one support to eat so they or their daughter chose to come to the home "nearly every day" to help the person with their lunch. Animals were also allowed into the home. One person told us, "My friend's dog and puppies have been in to see me. It was lovely to have them and they were so well behaved."

Requires Improvement

Is the service responsive?

Our findings

This key question was rated as 'requires improvement' at our last inspection and remains 'requires improvement' at this inspection.

Some people told us at times night staff were not as responsive as they would like them to be. One person said, "The night staff are slow to respond but come as soon as they can." They also said occasionally they had to wait a long time until call bells were answered. One person told us, "The idea of a buzzer is to make you feel safe because help will come. This can take a long time. I waited an hour the other night. I timed it as I have a clock opposite my bed." A relative said, "The call button is not helpful to mum. It's hard to push the button and then with her deafness she cannot hear the faint bleep so she doesn't know if she has been successful at pushing it."

We looked at care records to see if they demonstrated people received care responsive to their needs. . The record for a person we had spoken at length with on the first day of our visit told us the person had difficulty in speaking and could answer simple questions. It also said they could not use a call bell. This was at odds with what we found when we spoke with the person. We found as long as time was given when speaking with the person, they understood what was being said, and could provide us with answers. The person told us they were unhappy with the care they received and they did not get the care and support at the right time. They said their dinner was often cold and drinks were left where they could not get them. They were not able to use the call bell as identified in the care plan but this was not because they 'didn't know how to use one', but because their hand was constricted and they were physically unable to do so. The person clearly knew what the call bell was for.

The care plan also said the person was 'bed bound' but we saw them sitting in a chair in the lounge, and required positional changes when they were in bed to reduce the risk of skin damage. There was no information on their positional change chart about how often the changes were required. We looked at the chart for the week of the inspection. We found on three days, there were periods of five, six, and nine hours when the person's record showed no changes had taken place. This meant the person's skin could have been damaged as they were lying on one part of their body for too long a period of time.

One person told us they had been concerned because they thought their mattress had deflated. The person pressed the call bell and staff came and checked it. However, the person told us they were upset because one said to them, "It is 1am you know." The mattress was replaced the next day. The repositioning charts had a space for the mattress setting to be documented and for staff to check the setting was correct. We did not see this being completed. After our visit, the management team sent us information to confirm this was now being undertaken by staff.

Other care plans lacked detail. Two people who used 'admission to discharge' beds only had the initial admission sheet completed but further information had not been added. This was addressed during our inspection visit. Another person had been admitted for end of life care but nothing in their care plan reflected this. Medicines had been prescribed for this person in anticipation of them requiring pain relief.

However the pain had not been formally assessed to determine how or why they had pain. The care plan stated the person seemed 'brave and not anxious', but how this judgement had been arrived at, had not been documented.

Nurses said they struggled to complete care plans because of pressure of work load, comments made were, "They [management] should make the care plans easier to work with, and they are too complicated." The management team told us they were looking to simplify the paperwork of those using the 'discharge to assessment' beds.

Staff said they offered choice to people about when they received personal care, one told us, "Some like showers in the evening and we need to respect that and offer choice." However, they went on to say they were not always able to meet that choice when they were very busy. A person said, "I've loved having a soak in the bath. I've only had two; they don't do them in the mornings."

People's emotional and social needs were not met well. We saw care staff and nurses did not have time to sit and talk at length with people or engage in activities with them. This was identified at our previous inspection visit. The service had one activity worker who worked 38 hours a week and supported up to 55 people's individual and group activities. This included organising events and fetes to support the home. The activity worker had also been a member of care staff and so knew how to support people with their care needs. When staffing numbers were low they told us they were called on to help with care tasks. The management team told us the activity worker was not required to assist in care tasks but on rare occasions they might take people to an external appointment, or assist a person with a meal as part of their individual time with them if the person could not take part in more social activities.

We saw the activity worker try their best to support people with activities. One person told us, "They've put my bird table up outside. I can now watch the squirrels." On the day of our visit, they had set up a film afternoon and we saw some people attend the 'music lounge' where the film was being shown. We saw they had undertaken arts and crafts with people, and arranged exercise sessions, but they did not have time to provide much support to meet people's individual interests or to spend time with people providing reminiscence.

We found activities to support people who lived with dementia were very limited. This had also been identified by the service's regional manager, who in their last monthly report had said there was 'no evidence of dementia centred activities or evidence to suggest people were involved in activity planning'. In another recent internal inspection the organisation had also noted 'staff were observed completing tasks rather than engaging in meaningful activities…residents in rooms lacked social interaction. Activities and interaction logs were reviewed and these were poorly completed and would confirm social isolation.' We overheard one person saying, "This bloody place is the most depressing thing in my life."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

Our concerns about the lack of activities were voiced to management, who informed us after our visit that the company had agreed to fund an additional 25 hours of activity support.

People who used the ICU were pleased with the physiotherapy they received and felt this contributed to them being able to go back to their own homes.

Staff said they didn't always have time to read care plans. They also said, "There isn't always time to read

them but we ask the nurses for information." Staff felt there was good communication about people's needs from the nursing staff at the staff handover meeting (where one shift hands over information to the shift coming on duty) and throughout the shift. They felt nurses were knowledgeable about most people and their needs. One said, "Nurses give us good guidance and good briefings."

One member of staff told us, "It can take time to get to understand people's needs, so we ask families what they like." Another told us, "I try to find out about people's past so I can understand the person. We work closely with families, we learn lots of information and they tell us useful things."

We discussed with the management team how responsive the home was in relation to equality, diversity and human rights; and how it promoted inclusion for people of all religions, cultures and sexuality. The registered manager told us the LGBT community (Lesbian, gay, bi-sexual and transgender) would be welcome in the home. They were aware this was an area they needed to consider further and after our visit sent information of an audit tool they were starting to use to check the home was accessible and inclusive to all.

A copy of the provider's feedback policy for complaints, compliments and concerns was displayed in the reception area. Formal complaints were responded to appropriately and investigated by the person in charge. People and their relatives told us they usually spoke with staff in the first instance if they had any problems. A relative told us, "First of all I go to the nurses if there's a problem but they do keep complaints forms downstairs."

The dementia unit was being refurbished and redecorated. The organisation was making it easier for people to identify where they were in the unit by having signs and symbols on the doors and different colour paints on the walls. The doors to people's bedrooms were being changed to look like front doors to help people identify them as places they lived. Memory boxes were positioned outside bedroom doors which also helped people identify the door to their room. A large collage of pompoms which had been made with the help of staff, relatives and people, was on display in the lounge.

Requires Improvement

Is the service well-led?

Our findings

This service was rated as 'good' at our last inspection visit. At our last inspection visit the registered manager discussed the challenges of what was then called the 'intermediate care unit'. They spoke of people only staying for a short time plus changes in the way health and social care was provided, meaning more people were living longer in their own homes. This meant people's needs were sometimes much higher when they eventually came to live in the nursing home, so staff now had to be able to care for many more people with higher level needs.

Since then, staff told us they had seen a big increase in the number of people using the short stay service. They told us that whilst people could stay for up to six weeks, often they stayed a shorter period of time. This meant there was an increased turnover in people who used the home, and an increase in the volume of work staff needed to do to ensure people received safe and effective care. The nursing staff told us they had been telling the organisation about their concerns but these had not been listened to.
At our previous visit we had rated 'responsive' as requires improvement because we had concerns about the lack of activities for people who lived at the home. During this visit there continued to be a lack of activities. The activity worker and the registered manager had requested additional support to provide activities and they told us this had not been supported by the organisation. After this inspection the organisation confirmed they would provide an additional 25 hours to support an increase of activity work in the home.

The home had the same registered manager as previously. In recent months, the registered manager had to take unplanned leave. During their absence a less experienced manager was placed in charge of the service. They were supported by a regional manager. When a registered manager is absent from the home for a period of more than 28 days the service is required to inform the CQC. We did not receive a notification of this.

During this period, internal management audits identified shortfalls in the quality of service provided. At the time of our visit, the registered manager had just completed a phased return to work and was being supported by a regional manager to improve the service and to get it 'back on track.' The regional manager and registered manager agreed with our findings and showed us evidence that they had already identified and were working to improve some of the issues we had found.

Staff were positive about the registered manager's approach with them. They told us they felt supported by her. For example they said, "The manager is really good and reacts quickly to things," "I am very happy working here," and, "The management here is quite strong, you feel very supported."

Nurses on both units felt supported by the team of care workers who helped them with their work. One of the nurses on the dementia unit said, "We have a very good team up here. If things need to be done, we help each other out."

The registered manager had a legal obligation to notify us of any incidents, accidents or deaths which occurred at the home. Whilst the provider had not notified us of the registered manager's absence from the

home, the registered manager had met their legal requirements.

The provider had a legal requirement to inform the public of the home's rating. They had informed the public on their website they had previously been rated as overall 'Good', and a poster with their ratings was displayed near the lift in the reception area of the home.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and support which was responsive to all of their needs. People who lived with dementia lived with little engagement by staff and limited activities to provide them with fulfilling lives.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely and people' risks to their health and welfare were not always properly assessed or managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Nursing staff did not have time to undertake their roles and responsibilities systematically and safely. There were not enough care workers deployed on the first floor to ensure people's safety without restricting their freedom or independence.