Aden House Limited

Aden Mount Care Home

Inspection report

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Tel: 01484515019

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15 August 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place over two days on 9 and 15 August 2018 and was unannounced on both days. This was a comprehensive inspection. At the last inspection the service was rated as Requires Improvement overall with breaches of regulations relating to the consent of the relevant person to care and treatment, people's nutritional and hydration needs not being effectively met, sufficient numbers of staff not being deployed in such a way as to meet people's needs, and staff not receiving ongoing supervision.

When we completed our previous inspection on 8 and 11 May 2017 we found concerns relating to a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued a warning notice to the provider.

Following the last inspection we asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions of the need for consent, effective management of people's nutrition and hydration, and staffing. At this inspection we found that people's consent to care and treatment was not effectively managed, nutrition and hydration needs were monitored effectively, and we were not assured staffing levels were deployed appropriately to ensure people's safety and needs were met.

Aden Mount is registered to provide accommodation and personal and nursing care for up to 45 people. There were 44 people living at the home on each day of our inspection. Aden Mount is a purpose-built home offering accommodation across three floors, accessed by stairs and a passenger lift. One floor is designated for people receiving nursing care. At the time of the inspection there were two communal lounges available for people to use on the middle floor and one dining room. There was a separate activity room on the lower floor. Communal bathrooms were available on all floors, each room had an en-suite.

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

The home had a registered manager who was available throughout our inspection. 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.

People told us they felt safe living at Aden Mount Care Home and staff were knowledgeable about safeguarding processes.

There was little evidence people received care personalised to them. People's care plans and risk assessments associated with their care were not always regularly reviewed. Some people did not have appropriately recorded risks to their safety and these were not monitored effectively. There was little

evidence of people being supported and engaged in meaningful activity. This meant people's individual needs were not captured or being met nor were risks to people's safety.

Medicines and topical creams were not always administered safely. This meant there was a risk people would not receive the appropriate dose of medicines or receive medicines not as prescribed.

People, relatives and staff told us staffing levels were not sufficient and we observed the impact of this from staff's response to call bells. Training records showed not all staff had been adequately trained. This meant people were at risk from insufficient staffing levels and from staff not being adequately trained to support people safely.

Records did not accurately document people's needs and choices, and these did not show current guidance had always been followed. Documents did not always show whether people had consented to care and treatment.

There was a little choice for people in terms of what they would like to eat. People's nutrition and hydration was not always monitored. People's specialised fluid needs were not administered safely.

There was no record of manager checks on the day to day running of the home. Governance and audit processes were not robust and had not identified discrepancies in documents. Systems were not in place to effectively implement lessons learnt.

People, relatives and staff said waiting times for call bells to be answered were lengthy. Staff training was not up-to-date. Staff did not receive regular supervision or appraisals and there was little evidence staff's competencies were checked regularly.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Sufficient numbers of staff were not always deployed to provide safe and effective care and support. Staff had not received up-to-date training.

Risks to people were not consistently assessed and appropriate measures were not always in place to reduce risks.

Medicines were not always administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care plans did not adequately reflect their individual needs or how these should be supported.

Staff did not receive regular supervision.

The principles of the Mental Capacity Act 2005 were not always followed.

Is the service caring?

Requires Improvement

The service was not always caring.

We did not always observe caring interactions between staff and people who lived at the home.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people's needs, preferences, choices and personal histories and staff were not always aware of people's care and support needs.

People knew how to complain and complaints were monitored.

Relatives and staff did not feel their concerns were always listened and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff told us they did not feel the home was well-led and people and relatives did not know the registered manager well.

Accurate and complete records were not always kept in relation to the care and support provided.

The registered provider had up to date policies and procedures in place.

There was little evidence the registered manager had oversight of the day to day running of the home.

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

The inspection took place on 9 and 15 August 2018 and was unannounced on both days. The inspection team comprised an adult social care inspector, an inspection manager and an assistant inspector on the first day, and two adult social care inspectors on the second day.

Before our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. We contacted commissioners of the service, safeguarding and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well, and improvements they plan to make.

During the inspection we spoke with six people who lived at the home and five relatives. We also spoke with a visiting GP and a district nurse. We spoke with the registered manager, a senior carer, a nurse, an activities co-ordinator, a care assistant and the cook.

We looked around the building and saw the communal dining room, lounge, activities room and bathrooms and people invited us into their bedrooms. We spent time observing care in the communal lounge and dining areas to help us understand the experience of people using the service who could not express their views to us.

We reviewed a range of records which included seven people's care files, and three other people's daily

records, as well as medication administration records. We also inspected five staff members' recruitment and supervision documents, looked at staff training records, and other records relating to the management and governance of the home.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe, one person said, "Oh, yes, in an emergency then I wouldn't wait." A relative said, "Always someone around, and they check regularly." A staff member said, "Yes, people are kept safe here definitely," and another said, "Yes, people are safe." Staff we spoke with were able to describe safeguarding processes and what they would do to protect people from harm. Staff confirmed they would be comfortable discussing concerns with the registered manager. The registered manager explained how safeguarding and whistleblowing procedures are explained in induction and at supervisions. We saw from records these processes were followed and notifications submitted promptly.

A person told us, "There's not enough staff. I get breakfast in bed but would prefer to get up, I got [out of bed] at 11:30 today," and, "I press the buzzer and I have to wait a long time, then carers come and say 'bear with us'." Another person gave an example of when they had waited over 30 minutes to be assisted to move from their commode.

A relative said, "Carers don't have the time. There are less staff than before," and "There's been a 15 to 30 minute wait for [person's name] to be made comfortable," and "We went out in the wheelchair but because it was lunchtime there was a 45 minute wait." A relative gave an example when their relative had waited over 60 minutes to be assisted to toilet.

A staff member said, "It's soul destroying, we can't care for people properly because there's not enough staff." Another staff member said, "There isn't enough staff I would say, there's more staff on today than there normally is. I think they use agency staff to cover sometimes."

We observed many people were cared for in bed although some people's care plans suggested they should be supported out of bed. A relative commented this was because there were not enough staff to support people to get out of bed and told us they had to ask staff to get their relative out of bed.

A relative explained that at a 'relative's meeting' they attended recently concerns about the number of agency nurses had been raised and the registered manager had said it was being addressed. The relative said, "I've seen more [agency nurses] recently than before."

We concluded staff were not deployed appropriately to support the needs of people living at the home. On the first day of our inspection there were four staff, which included a nurse administering medication, supporting 22 people on the nursing floor, and four staff, which included a senior carer administering medication, supporting 21 people on the middle and ground floors. Most people required two staff to support them with all aspects of their mobility and many needed assistance to eat. On the second day of our visit there were 22 people living on the nursing floor and there was a nurse and four carers on duty. Staff said there were sometimes only three carers although most people needed two staff to assist them to mobilise or receive personal care.

Staff were recruited safely. We looked at the employment files of five staff and saw they contained an

application form including a full employment history, interview questions and answers, health declaration, at least two relevant references and proof of identity which included a photograph of the person. We saw that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. Checks to the Nursing and Midwifery Council (NMC) to establish registration numbers for two nurses weren't documented. These checks should help to ensure people are protected from the risk of unsuitable staff.

The registered manager told us dependency assessments were reviewed monthly to support staff deployment however we observed that whilst care plan reviews had taken place these did not accurately reflect people's needs.

On the first day of the inspection we observed call bells were ringing frequently and for long periods of time. On two occasions we witnessed call bells went unanswered for over five minutes. This was brought to the attention of the registered manager who arranged for these calls to be answered. We discussed this with the registered manager who explained the system did not allow them to monitor the length of time call bells were ringing. They also explained when a call bell was sounded it rang across all three floors of the home. This meant staff had to go to a panel on the corridor wall to see whether it was for the floor on which they were working, and would then answer if it was on the floor on which they were allocated to work. Staff told us they had been told not to leave the floor to which they had been allocated that morning. This meant staff could not go to another floor to provide support to someone who had rung their call bell.

On the second day of our inspection the registered manager explained the call bell system had been altered, following our feedback. This meant when a call bell was sounded it would ring only on the floor of the room from where it had been activated. We observed there was less call bells ringing throughout the home however call bells sounded frequently and constantly for periods between 9:30 to 11am. Between these times an emergency call bell sounded at least six times. We observed staff did not respond quickly to these. On each occasion one member of staff walked to the alarm panel, then to the person's bedroom and exited after cancelling the alarm. We observed one carer do this and told the person, "I'm not on this floor." The person pressed the alarm again. During the afternoon we observed a call bell ringing for over seven minutes. This showed there were insufficient staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because sufficient numbers of staff were not deployed to adequately meet the needs of people.

Staff commented they were confused by the new system. This was because when a call bell had been ringing for over five minutes it sounded on all floors as an emergency alarm. Staff said they didn't know whether this was an emergency or just a lengthy call bell response time. Staff explained they had been told not to leave the floor to which they were allocated. This meant there was a risk staff would not respond to emergency call bells promptly. The registered manager told us there were plans to introduce a new call bell system in September 2018.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service had not adequately assessed the risks to the health and safety of people living at the home.

Staff had not ensured people who were unable to move independently had call bells within reach at all times. At lunch time we noticed three people, who were unable to move independently, did not have call buttons within reach. One person was shouting for assistance and could not reach a call button.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service was not doing all that is reasonably practicable to mitigate risks to people's health and safety.

Medicines were administered from a locked trolley and were stored safely. Room temperatures and fridge temperatures were monitored and recorded. However a 'clinical equipment weekly check' had not been completed for the seven weeks before our inspection.

Medicines were not administered safely. When the senior carer was asked what the medicines they were administering were for they said they did not know and so were unable to tell people what medicines they were being given. We observed a chewable tablet being given to a person with capacity whilst they were in the middle of eating breakfast. The person put the tablet on the table to take later, however this medicine was recorded on the medicine administration record (MAR) as being taken. Training for the senior carer administering medicines on the day we inspected was out of date.

A person who received all medicines via a percutaneous endoscopic gastrostomy (PEG) tube did not have a care plan in place. A nurse described how they gave each medicine, either in liquid form or crushed tablets dissolved in water, separately and flushed the tube with 10 to 30 mls of water between doses. The service frequently employed agency staff and the person's relative, who visited for several hours daily, said most staff mixed all the medicines together in a large syringe. We checked fluid records and saw sometimes 250mls of water was administered with medicines and at others only 100mls. A nurse said when they administered morning medicines they usually administered 250mls of fluid in total in the process.

Topical creams were not administered safely. MAR charts did not record how these should be administered, for example, saying 'if varicose eczema flares spread thinly on affected skin only'. This meant there was a risk the cream could be spread in the wrong place. We raised this with the registered manager and was told topical medication administration records (TMARs) were kept in people's rooms. We checked three people's rooms who had been prescribed topical creams and did not find TMARs in any of the rooms. This meant prescribed creams could be over or underused as there was no record of when they had been administered or where. Body maps which record the location were not in evidence.

Medicines which are prescribed to be taken 'as and when' are known as PRN. PRN protocols had been put in place recently for some people however for one person there was a PRN protocol in place for a medicine which was recorded on the MAR as 'take one sachet daily'. This meant the information about this person's medicine was incorrect.

On the second day of our inspection there was a risk controlled drugs could have been administered twice. We observed handwritten MAR sheets had been produced for some controlled drugs however the printed MAR sheets were also available to use and record administration of this medicine. When we asked the nurse and senior carer administering medicines about this they were unaware of the changes. The registered manager explained they had made this change because controlled drugs needed two signatures on the MAR sheets and there wasn't enough room on the printed MAR sheets.

A staff member told us, "I administer medication and I did in house training for this last year and the Boots pharmacy training. I do have supervisions and my competency is checked as part of these and as the senior I'm responsible for ordering and storage. I don't often do medication rounds without being pulled away to do something else." This meant medicine administration was compromised.

Nurses and senior carers had medicines training every year, alternatively provided by the provider and Boots

pharmacy, competencies were checked every six months however this had not been done for one staff member who was still administering medicines. Plans were in place to do this although no dates had been arranged by the time of the second day of inspection.

We witnessed a thickener prescribed for one person being used to thicken drinks for all people requiring thickened fluids. When we asked staff how they knew the amounts to use to thicken each person's drink they said they 'just knew'. There was no recorded information used to check how people's drinks should be thickened. This meant there was a risk that staff who may not be familiar with people's prescribed thickener use would not know how these fluids should be prepared. Thickeners were prescribed for each individual person but were not used in this way.

The above demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service was not managing people's medicines in a proper and safe manner.

There was a risk to people's safety as we found people's care plans difficult to read. This would mean agency workers who were not familiar with people may not have access to all the information they need to keep people safe. People's care plans securely stored in locked offices however records for people living on the upper floor were stored on the ground floor, which meant staff would need to leave the floor to access them.

Risk assessments were not adequately in place. For example, we observed a person who had bed rails but there was no risk assessment in place for this.

People were at risk of an incorrectly sized sling being used to move them unsafely. On the first day of our inspection we observed slings used to move people were left around the home; one in a corridor, two in an unused but unlocked lounge. None of these had labels saying who they should be used for. We looked at the sling audit and found one of these slings had been checked but one had not. This was brought to the attention of the registered manager who explained these two slings were no longer used. On the second day of our inspection we observed these two slings had not been moved from the unused lounge: we observed a further sling, without a label, left in a communal bathroom.

The above demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service was not assessing the risks to people's health and safety.

People would be safely evacuated in an emergency. There was easily accessible personal emergency evacuation plans (PEEPs) about how people communicated, their cognitive function, and their mobility needs. These were in place in the four care files we looked at, and a copy was kept in the emergency evacuation folder. There was a risk people's support would not be provided appropriately in an emergency. Some of the information in people's emergency care plans did not reflect the information held in the care plans. For example, one person's emergency care plan said they could take their medication orally but their care plan said their medication should be administered by a PEG tube. This meant the person would be at risk of choking if they were unable to swallow their medication.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service was not adequately managing the administration of people's medication.

A recent infection control audit had highlighted areas for concern. The registered manager explained how a new cleaning schedule had been developed to address some of these concerns however we looked at the

cleaning schedule and found it did not record 'deep' cleaning of one bedroom from each floor every day. The registered manager had not identified this was not taking place. The registered manager explained that following the audit infection control training had taken place and 20 staff had attended. The training matrix showed staff had not received any recent training on infection control. A staff member had recently volunteered to be the infection control lead. A person told us, "[The carers] always wear gloves and aprons, and take them off when they go out and put them on when they come back in." Staff we spoke to were knowledgeable about infection control but training was not kept up to date.

The registered manager gave an example of how they had made improvements at the home, saying they had made arrangements for paperwork to be readily available rather than staff having to print out when needed. We observed people's daily records, which were kept in their rooms, were left in unorganised piles.

Another example of how the registered manager had made improvements at the home was to implement a wound file for each person so dressing changes could be recorded. This was in evidence.

Staff confirmed fire drills took place every week and that they had also taken part in mock evacuations.

Requires Improvement

Is the service effective?

Our findings

People were not able to choose their meals. A person we spoke with said, "At teatime I get whatever's around. We don't get offered any snacks." Another person said, "I'm a fussy eater so have soup all the time. My daughter used to buy ready meals for me but she's been told she can't do that." We observed lunch being delivered to a person in their room, we asked the person what they were having for lunch and they said, "I don't know what I'm getting," and "No one knows what's on the menu and [the carers] haven't the time to go to the kitchen to find out." This was confirmed by a staff member who said, "We no longer have time to offer people menu choices for the following day because there are not enough staff."

The cook said people could ask for something else if they did not like the choices such as a baked potato with different toppings or an omelette or a salad. We did not see this information was provided for people, and it was unclear if they knew.

The food provided did not always reflect the dietary needs of people. We spoke with the cook who said they knew about people's dietary needs. When we asked how they found out about people's dietary needs they explained staff tell them. The cook had a file with information about each person's preferences and dietary needs. This was not up to date and no one was responsible for updating or maintaining the file. The cook confirmed they weren't told why people needed certain foods however such information should provide exact requirements each person needed. The cook was not aware of any specialist assessments and did not have access to this information. The cook told us they sometimes made a diabetic pudding for people who needed this but these items weren't part of the regular food order. When asked what other pudding options diabetics could have the cook said they usually make pureed fruit.

People did not have access to regular snacks. The cook said snacks of biscuits, fruit and cake were offered to people in the morning and afternoon. They said no snacks were left out for people to help themselves but if people asked for something it would be given to them. People living with dementia might not retain information about available food if it was not repeated often or available to see.

Pre-admission assessments had taken place before most people had gone to live at the home. This allowed the registered manager to ensure the service could meet people's needs. Records for a person who had been admitted for short-term respite care over two months before we visited did not show a pre-admission assessment had been undertaken. Records showed a social worker had undertaken a mental capacity assessment for this person and had concluded the person had mental capacity to make their own decisions. Risk assessments had taken place when the person first arrived at the home but had not been repeated and the person had not been involved in these. The person had a high risk of pressure ulcers and falls. They were thought to be at risk of malnutrition but had declined to be weighed. No care plans had been developed. No consent forms had been completed or signed. The person required physiotherapy and had been visited on two occasions by a community physiotherapist who had recorded advice to staff. This had not been incorporated into a care plan and there was no evidence in daily records staff had acted on it. No plan was in place for the person's period of respite and there was no evidence staff at the service had taken responsibility for liaising with social services to prioritise a community placement. We brought this to the

attention of the registered manager who made immediate arrangements for these plans to be completed.

Supervisions and appraisals had not taken place regularly, in line with company policy. The supervision and appraisal tracker showed one staff member who had received regular supervision throughout 2018. Nine staff members had received only one supervision in 2018 when the company policy is for staff to have a supervision every six months. The appraisals matrix showed eleven staff had received an appraisal in the last 12 months. On the second day of our inspection a staff member said, "I had a supervision last week, I'm not sure if I've ever had one before."

Staff were not trained appropriately or received regular awareness about best practice. The home used a training matrix to monitor staff training however we noted less than half the staff had received up-to-date training in Fire Safety and training relating to people's capacity. Just over half of staff had undertaken Health & Safety training and only 19 out of a total 55 staff had received training about safeguarding. None of the staff who should have undertaken Care Certificate training had commenced this.
The above demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the service did not ensure staff received appropriate support, training, supervision and appraisal.

There was little evidence staff worked as a team. A staff member confirmed, "We used to take part in handovers all the time, every day in fact but we don't now. They used to keep us updated all the time with residents' healthcare needs but that doesn't happen anymore we just find out for ourselves."

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). Aden Mount Care Home had assessed people's capacity and made appropriate referrals to the local authority for DoLS authorisation.

Staff were not always clear about people's capacity to make decisions. This meant people were at risk of not being supported to make decisions and maintain their independence when able to do so. We asked a senior carer if a specific person had capacity to understand what medicines they were taking and was told, "I'd like to say yes". This was not clear from the person's medication care plan. Another staff member said, "'I have had training in DoLS [Deprivation of Liberty Safeguards] I'm not sure about MCA [Mental Capacity Assessment], I think on this unit there are three to four residents with DoLS I'm not sure without checking first."

The registered manager explained that people's capacity to consent to care and treatment was assessed prior to admission to the home and was reviewed monthly. We found capacity was not always assessed individually for some people. Speaking with the GP we drew attention to the capacity of one person at the home whom we felt required reassessment. They agreed that because of this person's condition, which by nature was changing over time, it may be that they no longer had the capacity to understand the seriousness of a decision that they had made relating to their care which may have very serious consequences to their health. We raised this with the registered manager and they said they would progress discussions about this with the family and the wider MDT. This meant that the home had not taken steps to reassess this person's capacity in light of their ongoing changing health.

People had signed to consent to care and treatment plans, photography, and sharing of information. We saw a relative had signed consent forms for a person with severe visual impairment. It was unclear if the person had mental capacity to make their own decisions. Mental capacity had not been assessed pre-admission and the person had been consulted about a decision not to resuscitate (DNAR).

An assessment of a person's ability to communicate showed they had good hearing and spoke quietly and a care plan advised staff to allow the person time to communicate. Recent daily care records stated, '[Name of person] manages to communicate [their] needs well', and '[Name of person] continues to communicate well, can express all [their] needs'. Four months after admission a mental capacity assessment had been made concerning the decision to choose healthy food appropriate for a diagnosis of diabetes. At that time records stated the person had a diagnosis of dementia and cited the person's inability to recall what was said two hours previously. It is unclear when or why a diagnosis of dementia was made and the ability to recall information for an extended period is not necessary for a person to make a capable decision within the framework of the Mental Capacity Act 2005.

The home had acted unlawfully in depriving a person of their liberty. The evening before our visit a person had asked to leave the building after midnight for a cigarette. Staff had refused to allow the person to leave even though the person had mental capacity to do so meaning this person was legally deprived of their liberty.

A nurse we spoke with was trained and knowledgeable. They were able to answer in detail the nursing care people required. However adequate care plans were not always in place and the service relied on agency nurses to cover many shifts highlighting that agency nurses would not be able to find detailed and precise care plans in place, for all the care needs of every person, to allow them to care for people effectively.

The home ensures people have access to chiropodists every 12 weeks and an optician every year. A district nurse we spoke with said the home had made appropriate and timely referrals for support. They explained there had initially been a lack of communication between staff but after speaking with the registered manager this had improved. They commented, "The carers have done exactly as I asked and I confirmed this with [person's name]. The carers are encouraging [person's name] to comply with my suggestions." A GP we spoke with said, "This is one of the better homes. They have always been good here."

When assessment showed a risk of malnutrition people's care plans were in place; people had been weighed more frequently and referrals had been made to dietitians.

Records showed the service referred appropriately to external health professionals and usually acted on advice from GPs, NHS Hospital Consultants, specialist nurses and therapists. Advice given by physiotherapists for one person had not resulted in a care plan and daily records did not suggest the instructions had been acted on. Advice to check pH level of gastric aspirate for a person with a PEG tube had not been acted on.

Requires Improvement

Is the service caring?

Our findings

People we asked said, "Staff are lovely." A relative told us, "The carers are nice and chatty but find it difficult to communicate with [person's name]." Another relative described a time when they observed a carer had responded to a person living at the home who had rung the call bell with 'what do you want?' because they didn't know the relative was in the room. This same person preferred to keep their room door open but told us, "The carers shut it anyway, I don't know what it says in my care plan, I'm not involved in reviews." During the second day we witnessed very few interactions between staff and people living in the home but people and relatives praised permanent staff. A relative said, "The permanent staff are brilliant." Another said, "[Name of person] gets very good care from the staff." Another relative said, "I feel like an outsider, it used to be friendly."

A staff member explained how they supported people in their choices, "People can always choose when they get up, some people go to bed early and some people go later. Some people choose to have their doors open as well when they sleep." We observed doors to people's bedrooms were not always open or shut as specified in their care plans.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because people's preferences were not met.

A staff member explained how they respect people's privacy and dignity, "We don't discuss people's care outside of the home or to any other residents." We observed staff knocking before entering people's rooms and people confirmed staff treated them with dignity and respect.

We observed staff generally being caring in their interactions with people. They made eye contact and were patient and respectful. Staff members were friendly but we did not observe that they spend time chatting with people. We saw one person being assisted to eat their breakfast, and during this interaction the carer did not ask or explain to the person what they were doing. The carer had not noticed that the person, who was sat in a wheelchair, had their legs dangling because footplates were not in use.

People's preferences were not supported. People's care plans contained a social history including the person's previous occupation and activities they enjoyed. We did not see this information had led to care plans to help staff provide meaningful activities for people. People who preferred to stay in their rooms or had care provided to them in bed were often socially excluded. We did not observe nor did daily records show interaction planned or activities available for these people.

We observed five people sat at five different dining tables in the communal dining room. These people were all in wheelchairs, all still wearing clothing protectors had not been moved from this area since breakfast, and were sat individually at empty dining tables without any meaningful activity taking place. At the same time the activities co-ordinator was sat in the empty adjacent lounge typing on a laptop. One of the people we noted was using a wheelchair which was labelled with another person's name.

The above demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because people's preferences were not met and supported.

People were supported and encouraged to maintain relationships with relatives and friends. During our visit we saw relatives involved in supporting people living at the home.

Advocacy information was available throughout the home.

Requires Improvement

Is the service responsive?

Our findings

A person said, "When staff are on holiday I don't see anyone, things become disjointed." Another person said, "I'm not interested in the activities they offer." Another person said, "I sometimes go down [to do activities] but activities [co-ordinators] are away so haven't been down for a week."

Another person told us, "Everybody has to wait their turn to go to bed, but I've been ill so they let me go early," suggesting people were not able to choose the time they go to bed. This person also said, "I haven't had one [bath or shower] for a couple of weeks," suggesting people were not supported to bathe or shower with the frequency they chose. Asked whether their relative is supported to bathe or shower a relative told us, "They ask but don't encourage when [name of person] says no because it's easier for them."

Risk assessments had been repeated each month. When scores indicated risk, care plans were in place to minimise risk. For example, a person with a risk of choking had a plan to sit up when eating or drinking. Assessments and care plan documentation also prompted assessors and reviewers to consider people's communication needs, preferences and characteristics protected under the Equality act such as gender, religion, sexual orientation and disability.

One of the key interventions to prevent the development of pressure ulcers is assisting people to change their position frequently. A person with a high risk of developing pressure ulcers had a care plan that stated they should be assisted to change position every two to three hours. We saw records they had been checked and repositioned every two hours during the night but very infrequently during the day. The records showed they usually spent about eight hours a day in their armchair and received personal care, on average once during that time. The person said if they used their call button they waited, "A fairly long time" for anyone to respond. The same person had a care plan for personal care and hygiene stating they preferred to take a shower once or twice a week. We asked them how often they had a shower and they said, "Never." Neither were they helped to get up in the morning when they wanted to. They said they woke up early but staff were not always available to, "get me up when I want to".

A person who chose to remain in their bedroom most of the time had been assessed as having a risk of social isolation. They had a high risk of developing pressure ulcers. We spoke with the person, in their room and they said sometimes they stayed in their armchair all day without leaving the room. Staff administered medicines and served meals to the person in their bedroom but we did not see staff spend time interacting with the person or encouraging any activity other than watching television.

We were not assured people had routine and appropriate access to meaningful activities each day. We saw that there were seven days on the staffing rota for August which did not have an activity co-ordinator. We discussed this with the registered manager who explained that on those days an extra carer working in the morning was allocated to support activities. We discussed with staff how individuals are supported to access activities and was told they don't unless they participate in the group activities however most people living at the home were cared for in bed. A staff member said, "There's not enough going on to stimulate residents…They pick and choose people they like to do activities with. One resident [name of person] they

always leave her out because [they shout]. They say they give people 1-1 in bed but they just go up there and say hello then fill in their paperwork to say they've done something."

Activities did not take place as planned. In the afternoon on the first day of our inspection a singer attended to sing to people in the communal lounge; this was not witnessed by the inspection team. On the second day of our inspection a beetle game was scheduled on the activity planner for the morning however we observed the activities co-ordinator typing records in an adjacent lounge whilst five people were sat at individual tables in the dining room without any activity taking place. A beetle game took place in the activity room during the afternoon of this day and eight people were participating. There was no evidence individual activities had taken place.

The above demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the service did not ensure the care and treatment of people appropriately met their needs or reflected their preferences.

People's individual needs were not always met. A relative told us agency staff were frequently used and these staff did not always know people's needs. A staff member said, "Sometimes it's shared with us but it depends what it's about, generally we don't get to hear about complaints. Residents and families know how to complain there's a complaints policy available as well."

We checked to see if the provider was compliant with the Accessible Information Standard which requires people who have sensory impairment or a disability have information available for them about their care in a way they can understand. We found the service was capturing, recording and meeting people's needs.

Concerns and complaints were monitored. The registered manager responded to concerns and complaints within company policy timeframes.

The registered manager explained how end of life care plans were discussed with people, or their relatives, if they did not have capacity to do so. We observed in one person's care plan that their wishes were recorded differently to that of the relatives' wishes. This meant people were at risk of not having their wishes met. A staff member said, "We don't have anyone on end of life care on this unit at the moment but we have received training in this area should it be required."

Requires Improvement

Is the service well-led?

Our findings

Ratings from the last CQC inspection had not been displayed on the registered provider's website. We brought this to the attention of the registered manager, the regional manager and the regional director. The regional director explained there had been a glitch with the 'widget' when the home had been bought in April 2018. We checked the website the day following the inspection and found the ratings were displayed on the website. Ratings were displayed in the reception area of the home.

A registered manager was in post and available during both days of our visit. People and relatives told us they did not know the registered manager very well. A staff member said, "The service could be better managed, there's a lack of communication from the management. [Registered Manager is] very office based we don't see [registered manager], it's not well-led…We feel so unsupported by senior management as well." Another staff member said, "The manager takes on board what we say but nothing ever comes of it. We don't get asked for our opinions." Another staff member said, "'I think the new manager's doing very well she was really thrown in the deep-end. A lot of people are resistant to change but [registered manager is] getting there and I feel supported in my role."

We spoke with the registered manager who explained their long-term vision for the home was to change the culture of the home and build on the existing rapport with families. The registered manager told us rotas had been changed and new policies and procedures were being implemented. The registered manager told us care plans were in the process of being changed to the new provider's documentation. They told us 20 out of 44 people's care plans had been changed to the new paperwork. One person who was living at the home for rehabilitation support did nothave any care plans in place.

The registered manager explained they kept up to date by checking the CQC portal for changes every week and also received alerts from the provider, which they have to confirm they have read. The registered manager also attends the regular local authority care home managers forum.

The registered manager told us they undertook a daily walk-round to monitor the home. There was no documentation available to support this and we observed that items left around the home, such as slings, wheelchairs, dirty pressure cushions, and dirty beakers had not been identified or removed. The registered manager had not identified people's daily records were kept in loose piles in people's rooms.

There was no record of the registered manager undertaking checks on the day to day running of the home. For example, relatives told us there were insufficient stocks of incontinence pads and staff told us it was the registered manager's responsibility to maintain stocks and order these. A staff member said, "If one thing could be improved it would be that we need more incontinence pads, there's a complete lack of them here."

People had not been offered a menu to consider their food choices for over a month and the registered manager had not identified this. An improvement plan which had been put in place following the infection control audit was for each bedroom to be deep cleaned each month, however cleaning records did not support this and the registered manager had not identified this.

Accident and incident reporting and an analysis of these were undertaken on a monthly basis by the registered manager. Governance meetings took place on a quarterly basis between the registered manager and the heads of departments however minutes from the last heads of department showed no one had attended.

The monthly health and safety meeting showed risk assessments had been undertaken for the refurbishment plans for the home. At the most recent meeting they had also discussed the procedure for reporting health and safety risks, as well as maintenance reporting and updates on recent fire drills.

Concerns raised by relatives had not always been actioned promptly. Relatives meetings did take place regularly. At the most recent meeting relatives had expressed concerns about the lack of water on tables during meals. On the first day of the inspection we observed that tables did not have water during breakfast or lunch. This was brought to the attention of the registered manager. On the second day of the inspection we observed water jugs on each dining table.

At the same meeting relatives said the water coolers around the home were always empty. On both days of our inspection we observed all the water coolers were empty. Other concerns raised during relatives' meetings such as the availability of fresh vegetables and changing the configuration of the dining room had been actioned.

Complaints and safeguarding referrals were audited by the registered manager on a weekly and monthly basis. The safeguarding folder documented the safeguarding referrals made to the local authority however there was no record of the outcome from the disciplinary meeting, any lessons learnt, of whether staff had been informed and learning implemented.

The above demonstrated a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the service had not in place adequate systems and processes to assess, monitor and improve the service to ensure people's safety.

Disciplinary procedures were followed and where concerns about staff conduct had been identified 'informal counselling' sessions had taken place between the registered manager and the staff member to identify best practice and lessons learnt.

Staff meetings took place every two months and the registered manager explained how they sent memos and questionnaires to staff to ask for their views if they had been unable to attend meetings.

Staff meetings took place regularly. It was not always recorded who had attended so the manager did not always have a record of which staff had been told what.

The registered manager described how the home had made links with the National Citizenship Scheme and volunteers from them had supported the home in refurbishing the activity room, patio and rose garden. There were plans for these volunteers to support the summer fayre. A local school had also undertaken three visits to the home and had spent time painting and playing ball games with people living at 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not contain sufficient information to support person-centred care which adequately met people's needs and preferences. There was evidence staff had refused a person access to a social activity without cause.

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 Sufficient numbers of staff were not deployed to adequately meet the needs of people. Staff had not been appropriately trained in some aspects of care.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care plans did not contain appropriate risk assessments relevant to the individual. Increased risks as a result of medication were not identified or managed. Medicine care plans for administration were recorded incorrectly. Topical creams were not recorded.

The enforcement action we took:

Issued a warning notice to the registered manager.
Issued a warning notice to the registered provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not operate effectively. There was no record of manager checks on the day to day running of the home. Daily record keeping was sporadic, the registered manager had not identified this during audits. Care plan audits had not identified the risks and omissions identified during inspection. Changes to medicine administration implemented by the registered manager had not been communicated to staff. The registered manager had not identified conflicting evidence of consent to care and treatment was found in care plans.

The enforcement action we took:

Issued a warning notice