Roche Healthcare Limited

Ashlands

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 11, 25 July and 5 August 2016.

At the last inspection on 22 and 24 September 2015 we rated the service as overall 'Inadequate' and in 'Special Measures'.

At the last inspection we identified seven regulatory breaches which related to dignity and respect, medication, person-centred care, meeting nutritional needs, good governance and the deployment of staff. Following the inspection we took enforcement action. The commissioners at the Local Authority and Clinical Commissioning Group (CCG) were made aware of our concerns and the registered provider voluntarily suspended accepting new placements. Following this inspection the provider sent us an action plan which showed how the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Ashlands is registered to accommodate up to 44 older people, most of whom have mental health and/or dementia related conditions.

At the time of our inspection the service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Although we found some improvements had been made in respect of privacy and dignity, we found a number of continued breaches in safe care and treatment, staffing, person-centred care, meeting nutritional needs and good governance. We also found a breach relating to premises and equipment.

Relatives and staff told us they thought people living in the home were safe and protected from abuse. Safeguarding notifications had been made to the CQC as required. Appropriate recruitment checks had been carried out to ensure staff were suitable to work with vulnerable people.

We found medicines were not managed safely as medicines were not check in to the home, stored and disposed of appropriately. People did not always receive their medicines on time and there were occasions when medicines were not given as prescribed. The use of topical creams was not robustly recorded. Medication competency was not checked for agency nursing staff.

Staff were uncertain how many people lived in the home and we found different instructions for staff to follow in the event of a fire. The registered manager had not responded to an identified need for further staff training in fire safety. Personal emergency evacuation plans (PEEPs) were in place, although staff were not aware they existed or where they could find them. Wall lights did not have covers fitted meaning people

were at risk of harm as the exposed wires were live.

Staffing levels were calculated based on numbers of people in the home and there was no assessment based on level of dependency. On occasions, door sensors were seen to be unanswered or cancelled by staff who did not carry out appropriate checks to ensure people's needs were met. Staff told us they felt more staff were needed.

The staff training matrix showed high levels of training had been completed. A programme of staff supervisions had commenced, although no staff appraisals had been completed.

The recording of people's fluid intake was not consistently completed and we saw the quality of support people received from staff at lunchtime was variable.

People did not always receive timely access to healthcare. Healthcare professionals gave mixed feedback about this service.

People were more appropriately dressed since our last inspection and their preferences regarding when to go to bed were respected. However, not all people wore appropriate footwear. We noticed this had improved by the third day of our inspection. People's privacy and dignity was observed by staff.

Care plans contained information regarding people's likes and dislikes as well as other personal preferences. However, we found gaps in these records which could lead to people's needs being missed or overlooked. Risk assessments were not always in place and staff did not take appropriate action to reduce risk as identified in risk assessments.

The quality manager was unable to demonstrate their oversight of the service as they did not have a system of checks in place separate to those carried out by the registered manager. The registered manager gathered information about the location, but did not analyse this to form meaningful action plans. Staff told us they liked the registered manager, but felt they needed a visible presence. The improvements identified in the registered provider's action plan following the last inspection were not evident during this inspection.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Medicines were not safely managed. People did not always receive their medicines as required. Medicines were not safely stored and the use of topical creams was not robustly recorded.

Staffing levels were determined based on numbers of people and did not consider their levels of dependency. Relatives and staff felt people were safe.

Risks to people were not well managed as people were exposed to harm which had not always been identified, documented or responded to appropriately.

Is the service effective?

Inadequate

The service was not effective

People did not always receive timely access to healthcare services. Mental Capacity Act (2005) (MCA) assessments were in place, although these were not always fully completed. Appropriate Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority.

A programme of supervisions had commenced, although no staff members had received an appraisal. Training completion rates were high.

The recording of people's fluid intake was poorly managed. Staff did not have access to information regarding people who required additional supplements. People received meals which looked appetising.

Is the service caring?

Requires Improvement

The service was not always caring

People wore appropriate clothing, although they were regularly seen not wearing footwear.

Staff provided variable support to people with some positive and

some poor practice witnessed. People's privacy and dignity was respected better since our last inspection.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were not consistently completed with accurate information. Relatives were invited to attend reviews.

Complaints were reviewed and found to be managed appropriately.

A schedule of activities was in place and trips out took place. However, activities were poorly recorded.

Is the service well-led?

Inadequate

The service was not well-led

Quality management systems in place were not effective as information was not analysed and used to create meaningful action plans and improvements. The storage of records was poorly managed.

The registered provider and quality manager were unable to evidence their oversight of the service to ensure continuous improvement.

Staff liked the registered manager, but felt they should have a visible presence in the home.

Ashlands

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.

This inspection took place on 11, 25 July and 5 August 2016 and was unannounced. At the time of our inspection there were 32 people living in the home. On the first day, the inspection was carried out by four adult social care inspectors and a pharmacy inspector. On the second day, two adult social care inspectors carried out the inspection and on the third day, two adult social inspectors, an adult social care inspection manager and a pharmacy inspector attended. On the first day we started the inspection at 06:00 and on the second and third days we started at 07:00. This was so we could speak with the night staff.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch made us aware of a concern shared with them and the local authority shared concerns from their most recent visit. We also contacted a range of care and health professionals who gave us mixed feedback regarding Ashlands.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with two people who used the service, five relatives, 17 staff members, the clinical lead, the registered manager, the quality manager and the registered provider. We also consulted with three healthcare professionals.

We looked at eight people's care records, five staff files, 15 medicine records and the training matrix as well as other records relating to the management of the service. We looked round the building and saw people's

bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2015, we rated this key area as 'inadequate'. We found the registered provider did not have systems for proper and safe management of medicines. Personal emergency evacuations plans (PEEPS) were not in place and fire alarm testing and fire drills were not being carried out. Staff were not deployed in a way to ensure people's needs were met.

We spoke with the registered manager about medicine management and they told us, "I don't think there'll be any issues."

At this inspection we found people were still not fully protected against the risks associated with the management of medicines. People did not always get their medicines at the correct time or in a way that met their individual needs and preferences.

We looked at medication records, medicines and other records of care for 15 people who were living in the home. We spoke with the registered manager and four nurses on duty about medicines management within the home.

On the first day of our inspection we saw medicines in current use were not always kept at the correct temperature. The fridge thermometer showed the temperature had been considerably higher at 14 degrees Celsius which is higher than the recommended safe range of 2-8 degrees Celsius; however, neither the registered manager nor the nurse we spoke with knew how to read and reset the thermometer correctly. Medicines may spoil and become unfit for use if they are not stored correctly. Waste medicines were not stored securely as recommended in the current guidance 'Managing Medicines in Social Care' (NICE 2014). NICE provides national guidance and advice to improve health and social care. Although people were not able to access this area, this meant staff members who were not authorised to handle medicines were able to gain entry to this room as it was unlocked.

Records for five people showed the quantities of medicines and nutritional supplements received into the home or carried forward from the previous medicines cycle had not always been recorded. This meant we were sometimes unable to calculate how much stock should be present and therefore determine whether or not people had been given their medicines and supplements correctly.

On the first day of our inspection we observed one person was upset and in pain. We looked at their medication records and saw prior to being admitted to hospital, they had been prescribed one or two codeine phosphate 15mg tablets to be taken up to four times a day when required. Following discharge, this dose was changed to one tablet to be taken four times every day. This dose change had not been effectively implemented on the person's return to the home and at least four doses of two tablets were administered before the error was identified.

We saw evidence of creams being administered without the use of body maps or other instructions regarding site of use. We also saw more than one cream product was recorded on the same chart, therefore

the provider was unable to clearly demonstrate which was used. We found creams prescribed to be used three times a day were only used once or twice daily. We asked the nurse on duty how they checked whether care workers had used these products correctly, but were told no such checks were made. This meant there was no effective system in place to ensure creams were used as prescribed.

We found people did not always get their medicines at the correct time such as with food and drink or when they needed them. For example, one person was given all their medication before breakfast, even though two of their medicines were clearly labelled to be given after food and another person went without their eye drops for two days as stock had run out. We saw at times people had not been given their medicines because they had refused them, were asleep or had been out of the home at the time of the medicines round. There was no system in place to ensure people were offered their medicines later. We saw other examples where medicines, including painkillers and an inhaler had been recorded as signed for but not actually given. The health and wellbeing of people living in the home was placed at unnecessary risk because they did not always get their medicines as prescribed.

Some people had difficulty taking their medicines and best interests decisions had been taken to give them their medicines covertly (without their knowledge and consent) some or all of the time. We looked in detail at records for four out of the nine people who were given their medicines covertly and saw in each case arrangements for the safe administration of covert medicines, as published in the NICE guidance document, had not been fully followed. One person's records showed they had missed 21 out of 84 doses of two different medicines in June 2016, even though arrangements were in place for these to be given covertly.

Many people were prescribed creams and medicines, for example, painkillers and laxatives that could be given at variable doses such as one or two tablets or only needed to be taken when required. We found care plans were generally in place for the use of these medicines, but there was not enough information available to enable nurses and care workers to give the medicines safely. This was of particular concern as the home frequently employed agency nurses who may have been unfamiliar with people living in the home; some of whom were unable to recognise or communicate their needs. There was no evidence pain assessment tools were in regular use to determine whether or not these people were in need of their painkillers. One person's care plan was incorrect and, if followed, could have led to the person being given double their prescribed dose of medicine. The lack of information and conflicting information about some people's individual needs and preferences meant they were at risk of not being given their medicines safely.

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

On our arrival on day one of our inspection, we asked a member of staff how many people were living in the home. They told us, "It's about 33, 30 plus." On arrival on day two of our inspection we again asked how many people were living in the home. We were told the number was 31. On each day of our inspection 32 people were living in the home. This meant in the event of a fire, staff would not have been able to correctly identify the number of people living in the home.

We saw PEEPs were available for staff to refer to in the event of a fire. On the third day of our inspection we spoke with three members of staff who were unaware PEEPs existed and where they could find them.

We saw fire drills were carried out monthly and involved staff from both day and night shifts. Feedback as to the success of the drill was recorded on the fire records; although there was no evidence the registered manager had reviewed these. We looked at fire records relating to 2016 and saw on five occasions the person carrying out the drill had concluded staff required further training. For example, on 25 May 2016,

when five members of staff had attended the drill the person had recorded, '5 mins before staff came down to the panel. Unsure of what to do. Only 3 members of staff came down. Went through what to do and spoke to other members of staff. More training needed.' We saw two versions of the procedure staff should follow in the event of a fire were on display. One was dated 2002 and quoted an assembly point not listed in the more up-to-date procedure.

We asked staff about fire safety. One staff member said, "I did a drill last week. I don't think there are really enough of us to evacuate the building at night." We asked the registered manager when the fire brigade had last assessed the fire safety at this location it had not happened in the time they had been in post (May 2015). Following our inspection, we contacted the fire service to arrange for them to visit and inspect the fire safety arrangements in place.

The registered provider's PIR stated, 'The home uses effective process for evaluating the risks of aggression and agitation associated with specific service users by assessing episodes of aggression and related triggers, behaviour and interventions. For service users for whom a specific risk has been identified the support plan will include a written plan to prevent/minimise risk'. We looked at the care plan for one person who had a history of aggression and violence. We saw a risk assessment for 'if the person left their room at night and went into another person's bedroom uninvited'. We asked the registered manager if there was a risk assessment for managing this person's violence and aggression. The registered manager showed us a document titled 'The Enriched Care Plan for [Name of person] - Communication.' However, this was not a risk assessment.

We looked at how the registered provider safely managed risks to people. We observed one person regularly moving around the ground floor whilst being supported by a member of staff. This person was particularly unsteady on their feet and we found their care plan stated they should wear footwear. However, throughout the second day of our inspection we saw they were only wearing socks. This meant they were at risk of falls. We asked staff about this and they told us the person did not have any laces in their shoes. We asked staff if they had looked at purchasing some laces and staff told us they would get some. Later, staff told us the person's feet had become swollen and the footwear did not fit them.

We saw some monitoring tools were not being used effectively to minimise risk. For example, one person's care plan stated staff should make fifteen minute observations of the person in order to keep them and other people safe from challenging behaviours. We saw staff had recorded checks half hourly on 10 July 2016. We looked at the observation records for this person dated 11 July 2016 and found no observations had been recorded between 07:30 and 20:00. We asked the staff member on duty why the observations were being made. They told us they did not know. Staff on duty during the day told us they were supposed to 'keep an eye' on the person, but were not clear about the risks to the person or others and what they were supposed to do. During our inspection we found staff were not always present to observe this person.

On arrival of day one of our inspection, night staff we spoke with were unsure how many people had bed sensors in place, although we were told everyone had door sensors to monitor their whereabouts. At our last inspection we found a variety of sensors continually sounding. On the morning of the first day of our inspection, the registered manager told us, "We've noticed a reduction." On the first day of our inspection, we heard sensors ringing throughout the morning. One staff member told us this was because the batteries in the door guards in communal areas were running out of power, which caused them to sound. By lunchtime we found the noise from the sensors had reduced. On occasions, we observed sensors were ignored by staff or cancelled without checking people's safety.

We concluded the above evidence demonstrated a breach of Regulation 12 (Safe care and treatment) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the premises and on the first day of our inspection we found three wall lights which were not fitted with a cover in the lounge area on the ground floor. We saw wires were exposed which were at a height people were able to reach. We checked this with the handy person who told us, "The lights are wired with the ceiling lights. If they aren't on then the bulbs must have gone. They'll be working. They're down to get changed when the whole refurb is done. The powers that be will decide when that is." One staff member told us, "[Name of person] wanders and touches wires and things he shouldn't." This meant people were not protected from the risk of harm if they had tampered with the wires. We immediately brought this to the attention of the registered manager who arranged for the handy person to refit the light coverings which we saw happened.

On several occasions, we checked the patio doors in the lounge and dining room areas and found both sets of doors were unlocked at times when these rooms were not supervised by staff. Staff made us aware of one person who had tried to exit the home via this route a month before our inspection. This meant appropriate action had not been taken in response to this incident. The management team told us they would look to introduce a sensor to alert staff when either set of doors were opened. On the third day of our inspection we found the patio door unlocked to an area outside the dining room where a step had been removed as part of ongoing works. At this time, there were no members of staff in this area. This meant people were at risk of falling due to the distance to the ground.

We found the second floor looked worn with damaged wallpaper and stains on the flooring. On day two of our inspection we saw the dining room on the ground floor was being redecorated. We also saw changes had been made to improve decoration in the ground floor corridor. We found the refurbishment plan which commenced in May 2016 showed works were only scheduled for the ground floor.

We concluded this was a breach of Regulation 15, (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence of maintenance checks including; gas safety, water temperatures, legionella, PAT testing and fire checks including extinguishers had been completed.

At the time of our inspection we found there were 17 people living in the home who required two members of staff for aspects of their care.

We asked staff whether they felt there was enough staff on each shift. Staff comments included; "Sometimes there is" "No. Any time after four it's okay" "Staffing has been better" "I don't think there are enough staff at night" and "We are always saying we need one more." In the June 2016 relatives meeting it was recorded, 'people present only had concerns about staffing levels'.

We asked the registered manager how they calculated the number of staff needed on each shift and were told the registered provider had a policy of providing one member of staff for every five people living in the home. The quality manager told us every person in the home had been allocated a set number of staff hours which was the same for each person. This meant the registered provider did not have a robust system in place to ensure staffing levels were based on dependency levels of people living in the home.

In February 2016 the night staff routine and allocation record stated, 'Through the night one carer (female) will be based on the top floor'. We asked staff about the arrangements for staff cover on the top floor and were given different accounts of how this was managed. One staff member told us, "If we need help with

someone that is 2:1 we use the nurse call system. We do cleaning when we are on at night. I come up every hour to check people on the top floor." Other staff told us a staff member remained on the top floor through the night. The registered manager told us the top floor was always staffed on the night shift. We asked the registered manager if they had carried out any night checks since our last inspection and they told us this had not happened.

We saw there was only one person on duty on the top floor on the night shift, and observed they were not always present when people needed them. One person's door sensor was observed to be ringing for 20 minutes before the member of staff returned to the floor. The member of staff did not check the person's whereabouts until prompted by us. They told us they assumed the person was in the toilet.

We looked at the staff rotas over a four week period and found staffing arrangements were covered as the registered manager had indicated. We found there was a high usage of agency nursing staff on night shifts, although a level of consistency was provided as the same agency nurses had worked in the home for several months.

At this inspection we saw more interaction between people and staff than we saw at our last inspection. However, throughout the inspection we saw people lacked stimulation and interaction for long periods. People vocalising received little attention or reassurance from staff when they were distressed.

We concluded there was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to ensure people were protected from abuse. One relative we spoke with told us, "She's well looked after." Staff we spoke with felt people living in the home were safe and protected from harm, although when we asked a staff member if they would place a relative in Ashlands. They told us, "It would depend on certain members of staff." Another staff member said, "I'd put my mum in here. There are good carers."

Staff were able to identify different types of abuse and told us they would report any concerns to the registered manager or head office. We found safeguarding notifications had been submitted to the CQC as required under the terms of registration. Training records we looked at showed all staff were up-to-date with safeguarding training which they received on a three yearly basis.

We looked at five staff files to assess whether the recruitment process followed by the registered provider was safe. One staff file we looked at contained a DBS dated January 2016 from a previous employer. The staff member commenced employment in April 2016. The registered manager told us, "If the DBS was three months old, I would look at starting on that." The registered provider's recruitment policy stated, 'The company will require all applicants for employment will be subject to application to the Disclosure and Barring Service (DBS) to obtain information to enable it to assess the suitability of applicants for employment in positions of trust'

We saw references had been taken and checks to establish identity had been completed. We also looked at the records concerning registrations of nursing professionals and found appropriate checks had taken place.

Inadequate

Is the service effective?

Our findings

At our last inspection in September 2015 we rated this key area as 'inadequate'. We found people were not supported to have a balanced diet that promoted healthy eating and met their assessed needs. We also found some gaps in staff training and staff supervisions and appraisals were not taking place. Referrals were not always made to health professionals.

At this inspection staff told us they were satisfied with their induction which involved three days training at the registered provider's head office and shadowing other staff. Training records we looked at demonstrated high levels of completion rates in a range of topics. The registered provider's PIR stated, 'Training is delivered on induction and yearly thereafter'. We found this was not the case. Other than moving and handling, fire safety and infection control, staff training was refreshed every three years.

On the first day of our inspection we asked for a copy of the supervision policy. An up-to-date version could not be located. We were told by the registered manager the quality manager may have this on file. On the second day of our inspection, the quality manager told us they did not have an up-to-date copy of the supervision policy. The registered manager did find a version of the supervision policy dated 2007 which stated supervisions should be provided on a monthly basis. Following the inspection, we were provided with an up-to-date supervision policy by the registered provider, dated April 2015. However, the supervision policy did not state how often staff should receive supervisions.

Comments from staff regarding supervision included; "I had my last one a couple of months ago. We talk about how the job is going and things we are concerned about. It's one to one and we can speak up", "I think it's every six months. We get to have our say" and "Mine took ten minutes."
We asked the registered manager about supervisions for staff and they told us, "We're pretty much up-to-date." We saw a programme of supervisions had started, although some were overdue and in some instances, six months had elapsed between supervisions. We saw no staff appraisals had been carried out since our last inspection.

We concluded this was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager did not ensure staff received appropriate supervision and appraisal to enable them to carry out their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

The training records we looked at showed staff had received MCA training and staff confirmed this. We found staff had an understanding of the mental capacity act and how this affected their role. One staff member said, "If people can't make a decision, I would prompt them to get a response. Best interests decisions are made on people's behalf when they can't choose."

We saw some evidence of staff giving people choices. We overheard a staff member giving a person choice for their breakfast. Once the person had decided they wanted porridge, the staff member asked, "Would you like some golden syrup on top." Care records contained consents for inspection of care records and the use of the person's photograph.

We found some care plans contained decision specific MCA assessments which had been well written. However, one care plan contained no capacity assessments. Another contained the assessment 'able to make simple decisions', but there was no information relating to what these decisions were. We saw reference in risk assessments and care plan reviews to the people lacking capacity in respect of specific decisions. The MCA assessment for one person had a section which stated 'Clearly state the decision to be made' which we found was blank.

We saw records of consent forms which had been signed and evidence of discussions with families concerning best interest decisions. One person's 'Continuous care and treatment' care plan stated they were at risk as they were unable to recognise the need for good hygiene. We saw relatives had been consulted regarding a best interest decision for this person.

We saw evidence of Deprivation of Liberty of Safeguards (DoLS) applications which had been made to the local authority. We found some staff were unsure who DoLS applied to. One staff member said, "DoLS is deprivation of liberty safeguards. I don't know if anyone up here has one."

We looked at how the registered provider ensured people's nutrition and hydration needs were met. The registered manager told us, "We've done a lot of work on nutrition and hydration." New menus were being introduced in August 2016 which they told us would be more nutritious and offer more choice. This had been developed in association with the National Association of Care Catering. We asked if people in the home or relatives had been consulted and were told this had not happened.

One relative said, "The meals look great, they're really good."

The registered manager told us one person living in the home had involvement from a dietician at the time of our inspection. They also said people who needed nutritional supplements were given smoothies and shakes. Staff we spoke with confirmed this happened.

Night staff told us they had access to the kitchen and offered people snacks including cakes, biscuits, fruit, 'ready brek' and custard.

We found a list of people who had special dietary requirements in the kitchen. These records listed people's individual allergies, food likes and dislikes and any adaptations they needed such as specialist crockery and cutlery. They also showed who required thickeners including the appropriate level. However, when we asked for information on who needed nutritional supplements, one staff member told us all food was fortified. We found there was no record of people who needed nutritional supplements in the kitchen or on the tea trolley. We discussed this with the registered manager who showed us this information was on their desk. They told us they were unsure why the staff had not asked for this information. On the third day of our inspection we saw this list was in the kitchen. However, one person whose medication records showed they

needed a nutritional supplementary drink was not listed as needing this.

We looked at fluid records and found these were not well managed. We found staff consistently recorded 200ml of fluid had been received by people. Some staff told us they only recorded the fluid given to people rather than the amount they drank. The registered manager told us, "Food and fluid intake is recorded for everyone after each meal. Information from the food and fluid charts would be flagged up at handover. For meals it is recorded if people have eaten a full or half portion. There is no accurate picture of people's fluid intake." We looked at the fluid records for one person over a period of 28 days in June and July 2016 and found they received on average under 650ml per day. The National Association of Care Catering guidance on fluid intake for older adults states; 'A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day'. Care plans did not contain information relating to how much people should be encouraged to eat or drink.

This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nutrition care plan for one person dated May 2016 stated staff should offer meals and leave them in front of the person. Staff were seen following the care plan by asking the person if they wanted to eat and when they declined, staff followed the care plan by leaving toast and tea; every few minutes they asked the person if they would like to eat breakfast. This was done in a gentle way.

We saw people were offered a choice of two main meals at lunchtime. The food looked hot and appetising. We heard one staff ask the chef for a fork-mashed meal for one person, They said, "That will mean the fish." This meant the person would not have had a choice of meals.

On the first day of our inspection, people were offered spaghetti on toast for breakfast. On day two, we saw people were given a cooked breakfast for lunch. This may have been confusing for people living with Dementia.

During lunch the nurse gave medicines to people as they were eating. One person being assisted to eat was not asked if they wanted their medicine, and the member of staff assisting them had to stop and wait until the nurse had finished.

During our inspection we found people did not always receive prompt access to healthcare when they needed this.

On day one of our inspection we spoke with a member of staff who told us they had reported concerns about a red mark on one person's foot to the nurse at 22:30 the night before our visit. We saw this person was not wearing socks and had footwear on which rubbed against their injury. We brought this to the attention of the nurse at 06:30 who went to get a dressing for the wound. We saw they applied the dressing in the lounge which did not respect this person's privacy and dignity. We discussed this with the registered manager who agreed this was not good practice. On 13 July 2016 we saw a GP visited to look at this person's foot.

On day two of our inspection we followed up concerns identified during the nursing verbal handover on the morning of the first day of our inspection. One person had been identified as suffering with constipation. We found there was no record of any treatment or consultation regarding this. We asked a member of staff who told us, "We requested for some lactulose." After being unable to find a record of this request they told us, "It hasn't come. We should've followed it up really." Another staff member said, "It stopped some time ago as it

was making her loose."

On 11 July 2016 one person had been identified as having sticky eyes during the morning nurses handover. We found eye drops were not administered to this person until the evening of 15 July 2016. The treatment for the person had lasted for one week. On 20 July 2016 a telephone review with the GP took place which stated, 'Eyes much improved'. On 25 July 2016, we saw this person and asked a nurse whether they thought the person's eye condition had cleared up. They told us, "It's still slightly red and not fully opening." We asked the staff member what action they were planning to take and were told, "It will be for the GP to review." On 26 July 2016 a healthcare professional instructed a swab should be taken in the event the eyes became weepy. On the third day of our inspection, staff told us they had been unable to obtain a swab and were bathing the eyes with water twice a day. We saw the decision to bathe the person's eyes had been recorded on their short term care plan on 04 August 2016.

During our inspection we contacted a range of healthcare professionals who gave us mixed views about staff knowledge and action taken in response to people's healthcare needs.

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

Requires Improvement

Is the service caring?

Our findings

At our last inspection in September 2015 we rated this key area as 'inadequate'. We found there was a lack of respect for people who used the service and staff routines took priority.

At this inspection we saw there had been some improvements. For example, on both days of our inspection we found people who preferred to stay in bed had their wishes respected. We saw people were more appropriately dressed.

However, we observed a number of people were not wearing footwear. We asked one member of staff about footwear. They told us, "Some won't wear them. During the middle of the day they take them off. If you go back to them later in the day to prompt them, they'll usually put them on." On the second day of our inspection we saw one person at 07:15 wearing odd socks. We asked a member of staff about this and they did not know why this was the case. A short while later the person's socks were changed for a matching pair.

During lunchtime we observed three people receiving assistance with their meals. We saw one member of staff who was focused on the person they were assisting. They spoke to the person and used encouraging language, asking the person if the food was nice and saying, "This smells delicious." When the person became agitated the staff member helped them relax by talking to them about the weather and a visit from their family.

One person was supported to eat independently. Staff checked they were holding cutlery correctly and positioned their plate so the person could access this easily. Periodically the member of staff came and re-positioned the cutlery and plate.

We saw another member of staff did not engage with the person they were assisting. They did not check the person had swallowed the food in their mouth before offering more, and gave the person their meal in a hurried, functional way. We saw the member of staff chat to a colleague about their holiday, but did not see them speak with the person they were assisting.

Staff we spoke with were able to tell us about the preferred routines, likes and dislikes of some of the people they provided care and support for.

We saw when one person became tearful a member of staff gave them reassurance and spent time chatting to them. They offered a bubble bath and chocolate and spent one to one time with the person until they settled, and also informed the nurse the person had become distressed.

One staff member told us staff volunteered to go on trips in their own time to enable people with significant care and support needs to take part. We saw this happened on day two of our inspection.

Staff were able to describe how they protected people's privacy and dignity. One staff member said, "I knock on doors before I go into rooms. When I am giving personal care, I make sure the doors and curtains are

closed, especially when I am changing someone." We observed one member of staff knocking on doors before they entered people's rooms. Relatives we spoke with told us they were satisfied staff respected their family member's privacy and dignity.

We saw a note in the July 2016 staff handover sheets which said, 'Seeing the doctor in the lounge is not acceptable and has to stop from today'. This meant the registered provider had recognised the need for people to have private consultations.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2015, we rated this key area as 'requires improvement'. We found care and treatment was not appropriate and did not meet people's needs. Care plans contained sketchy information including life histories, likes and dislikes. We found very little stimulation through activities.

At this inspection we were told care staff were responsible for writing daily notes, whilst nurses updated care plans. One staff member told us, "We don't see the care plans. We can, but they are all in the office at the front." Staff we spoke with were able to tell us how they met people's needs.

Care plans contained evidence of basic personalisation in the 'biographical details' section. The registered manager told us they were still awaiting responses from a number of relatives concerning people's life history which they wanted to add to care plans. Care plans contained information regarding people's likes and dislikes as well as other personal preferences.

Care records contained risk assessments relating to a number of specific areas including non-consensual relationships, moving and handling, falls, malnutrition, locking bedroom doors and skin integrity. Risk assessments were reviewed monthly with statements to show what had changed or whether the assessment remained valid.

Supplementary records were completed as part of the care planning process. We found the positional change chart for one person stated, '[Name of person's] positional changes to be done through the night by nights'. As it was not stated, we asked staff how often this person should be turned and were told every two hours. In the sleeping care plan, it stated 'Check on [name of person] regularly through the night according to policy'. This meant staff did not have specific information relating to this person's needs. We found staff routinely recorded their checks as having taken place on the hour, every two hours. We saw another person's 'pressure care management and prevention' care plan dated January 2016 stated, 'To reposition [name of person] every four hours'. We saw their positional change chart showed staff usually repositioned them every two hours and were not therefore following the care plan guidance.

The epilepsy guidance for staff to follow in the event of one person having a seizure was detailed, although the type of epilepsy and how the seizure would affect the person was not stated. We saw a clinical audit dated May-June 2016 in which the registered manager noted timescales for taking action following a seizure were needed. We saw these had been added to the care plan for this person.

Records of daily notes were not always dated which made it difficult to establish which date they referred to. We looked at daily notes and found recording of baths and showers had not always been documented. We asked one member of staff if baths and showers took place. They told us, "They are, as we have seen, some staff are not recording them."

Care records contained a log of GP visits and records relating to other health professional input such as from specialist diabetic services.

The registered manager told us care plans were reviewed on a monthly basis and every six months people's care plan were reviewed with the involvement of relatives, where possible. We saw evidence of reviews taking place in the care plans we looked at. Relatives we spoke with confirmed they were invited to reviews.

An activities coordinator was in post and worked four days a week. When they were not available, staff were expected to provide people with stimulation and activities.

There was a planner on the wall which listed the activities for the day. On the first day of our inspection we saw these listed as 'Newspapers', 'Ice Creams in the Garden' and 'Sensory and music'. The activities co-ordinator told us 'Newspapers' meant they read newspapers with or for people, although we did not see this happen. 'Ice creams in the garden' was cancelled due to poor weather. We saw people had some opportunity to join in with games of noughts and crosses before and after lunch. These games were short and involved one or two people at a time. We saw the activity programme was repetitive. For example, 'Newspapers' was an activity planned for four occasions and 'Watching television' on two occasions. Hairdressing was also listed as an activity. We saw there was a programme of additional events including trips out and singers who were booked fortnightly.

On the second day of our inspection we saw six people enjoyed a day trip. However, no activities were provided for other people who stayed in the home. In the morning we saw some reading of the newspaper, although the activity was not well organised. The activities co-ordinator kept breaking off to ask staff to attend to call bells, or asked staff who had come in as volunteers for the trip to take over.

We looked at the activity records for five people. We found significant gaps in the recording of activities. For example, there was no record of activity from 21 May to 04 July 2016 for one person. We asked a member of staff about missing records and they told us, "I don't know where the others are." Activity records we looked at contained reference to visits and trips out with family members. One activity was recorded as 'had hair styled'. Activity records lacked information about the person's participation or how they had benefitted from participating.

This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not consistently provided with meaningful and stimulating activity.

We saw a notice on display in the home relating to making complaints. This stated, 'If you have issues or concerns or compliments please complete a feedback form.' There were no feedback forms on display for people to complete. We looked at two complaints which had been received since our last inspection. We found records of an acknowledgement and a final letter sent to the complainant which identified the action taken by the registered provider. One relative told us they were satisfied with how their complaint was handled.

Inadequate

Is the service well-led?

Our findings

During our last inspection in September 2015 we found a total of seven breaches of the regulations. In response, the registered provider sent us an action plan which identified how they would meet the regulations with timescales. At this inspection we reviewed the action plan with the registered manager who indicated the majority of actions had been completed. The registered manager commented, "I think we have improved." At this inspection we found evidence of limited improvement in some areas but other issues identified at the last inspection had not been remedied. It was evident the concerns we found at this inspection had not been identified by the management team.

On the first day of our inspection, we asked the registered manager to show us evidence of how they assessed and continually improved the quality of the service. The registered manager told us they had introduced several audits since our last inspection. For example, these covered; infection control, clinical notes, medication, health and safety and in depth review of five to eight care plans every month.

The registered provider's PIR stated, 'Care and services will be monitored through audit and surveys to measure success and address any issues that arise. Although the registered manager completed regular audits of the medicines and records, the audit used had failed to highlight any of the concerns and discrepancies we found. Where issues had been identified, we were not able to see exactly how these issues had been addressed.

We looked at the registered manager's audit of accident and incidents. In May 2016 we found 29 incidents/accidents had been recorded, of which 16 were falls. The analysis did not state the nature of the other 13 accidents/incidents. We saw records of locations and times of fall, although it was not clear what actions or follow up had taken place when the quality management information had been audited. There was an action plan for the month and a review of the action plan from the previous month, but this was not always completed and lacked detail.

We looked at the monthly infections and risk management summary which recorded people's infections each month. An analysis and report was completed and actions were also recorded.

The registered manager provided us with a health and safety audit carried out in January 2016 which was a handwritten document. There were no timescales for these actions and we saw less than half of the actions recorded had been completed.

The 'manager's report', which completed by the registered manager contained an overview of weight management, falls risk, end of life care, do not resuscitate, DoLS and care plan evaluation. We looked at the records completed since January 2016. In one case, we saw a person whose weight had reduced between March and June 2016, although in the same period the person's BMI had increased. There were no actions recorded on the managers' report. The registered manager told us they had not addressed any actions from the managers' report, but they were going to start this with immediate effect.

The clinical notes audit for May/June 2016 stated 'Need to evidence attempts to weigh and action taken' for one person. The same person's care plan showed they were not being weighed regularly and did not indicate where the person had refused to be weighed therefore this action had not been addressed.

The registered manager told us they did not carry out formal spot checks, but did observe staff practice. They told us, "I wouldn't record it." Staff we spoke with told us they felt the registered manager spent much of their time in their office. One staff member said, "I think she could do with getting out of the office a lot more. Make sure everybody's doing their job properly." Another staff member said, "I like [name of registered manager]. It would be nice to see her out on the floor more." In June 2016, a relative commented in a survey sent out by the registered provider, 'I also think that once in a while, you [name of registered manager] should work a weekend and be "hands on" so you are aware of what goes on too'.

At our last inspection we found staff appraisals were not taking place. The registered provider's appraisal policy dated April 2015 stated, 'In this organisation: All staff should have an annual appraisal with their line manager or supervisor. The action plan we received from the registered provider stated all staff appraisals would be completed by March 2016. At this inspection, the registered manager told us they had not carried out any staff appraisals since our last inspection and said this would happen by August 2016.

The quality manager told us they reviewed complaints, safeguarding and medication; although they told us their checks were carried out jointly with the registered manager. This meant it was not possible to see evidence of oversight from the quality manager in assessing quality management. We asked if the registered manager received supervision and were told this happened, although there were no formal records.

We looked at the results from the January and June 2016 resident and relative surveys and found the responses were mostly positive. We saw this information had been turned into graphs, although the results of the surveys had not been communicated to the people who participated. Staff surveys had also been completed.

The registered provider had a programme for 'resident of the day'. We asked the registered manager about this and they told us, "It's very diluted." Staff we spoke with told us this might involve having nails painted, a hand massage or checking people's rooms to ensure they had everything. We asked a staff member who the resident of the day was and found they were unable to identify this person. They told us this would be on a worksheet, although they could not locate this when we asked. Following our inspection, we received evidence which showed the name of the resident of the day written in the diary in the office. However, this did not translate into action to improve the experience of the person who should have benefitted from the resident of the day experience.

We saw a memo in the handover book from March 2016 which stated, 'Please be aware that as of today we have computerised access to the call log system and we can track the length of time the call bells are activated for before being answered. If the log shows that the activation time is excessive we will require a report as to why'. On the first day of our inspection the registered manager told us they did not have an analysis of call bell times to show how quickly staff responded to buzzers.

On the third day of our inspection we asked the registered manager for copies of the previous four weeks nursing handover sheets. We looked at the records provided and found numerous gaps in the recording of handovers. In total, we found 13 dates between 01 and 21 July 2016 when either or both records for the ground or first floor were not available for us to look at. We were not given copies of handovers for the fourth week in July 2016.

The registered provider's PIR stated, 'The managers daily walkabout provides an opportunity for staff/service users to raise concerns/comments/compliments. The records we saw for the 'manager's daily walkabout' during June 2016 evidenced this did not happen on a daily basis. The registered manager was unable to locate the records for their daily walkabout for July 2016.

We found systems for storing documentation not recorded in care records were particularly disorganised. Food and fluid charts and other documentation we requested was not stored in an orderly fashion and took considerable time to locate. Since our last inspection in September 2015, two relatives meetings had taken place, although records for a meeting in February 2016 could not be located.

We concluded this was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw full staff meetings had taken place in February and June 2016. Other meetings for individual teams such as housekeeping, team leaders and nurses had on occasions taken place.

Staff gave positive feedback about the registered manager. Comments included; "Sometimes the manager is still here when I come in or go home. I think the home is well-led. The manager and clinical lead are approachable and listen when we tell them things", "Things are a lot better than it was. Staff are getting on. We're all helping each other. [Name of registered manager] is doing well" and "There is fair leadership. We know where we can go for help. [Name of registered manager] is mainly in the office, but will come and help on the floor. She is fairly supportive."