BC&G Care Homes Limited

Ambassador House

Inspection report

31 Lansdowne Road
Luton
Bedfordshire
LU3 1EE

Tel: 01582486244
Website: www.bcgcarehomes.co.uk.

Date of inspection visit:
12 December 2017
13 December 2017

Date of publication:
19 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service in October 2016 and rated the home as Requires Improvement overall. When we inspected the service on 12 and 13 December 2017 we rated the service as Requires improvement . This is the second time Ambassador house has been rated as Requires Improvement. This inspection was unannounced.

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

Ambassador House provides personal care and accommodation for older people. With the exception of one person when we visited most people were living with some form of dementia. Ambassador House is registered to provide care for up to 25 adults. At the time of the inspection 18 people were living at the home. Ambassador house comprises of a building offering accommodation over three floors.

There was a new registered manager in place. 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.

When we visited the home we found there were issues with the temperature of some people's rooms and the communal parts of the home. This issue had not been identified and addressed by the registered manager and staff on the day. The inspection team needed to prompt the registered manager to take action to address this important issue. The provider had not adequately addressed the long term issue of the heating system. We found that parts of the premises were in a state of poor repair. We also identified infection control issues.

One person's property was not being protected and some staff did not have a good understanding of how to protect people from harm. Staff recruitment checks were not robust.

People were not always being given choices of what they ate and drank. Drinks were not being offered to people on a regular basis. We found short falls in one person's food and fluid chart. Which meant we could not be certain that their nutrition and fluid levels were always being met. People's food was not always warm when they ate it. The service had not considered people's dining experiences or meaningfully asked their views about the food and drinks.

Staff did not always promote people's dignity and respect. Confidential information was not always stored securely. People told us that staff did not always knock when they entered their rooms or wait to be invited into their rooms. We saw that staff were not always mindful of promoting people's dignity when applying people's medical creams in communal areas of the home. We also saw that steps were not taken to protect

the dignity of a person who had become in a state of undress in the communal part of the home.

People's social needs were not being meaningfully explored with them. Lifelong interests were not being promoted by the service. Staff were not chatting and engaging with people.

Quality monitoring checks by the provider had not identified these issues. Therefore plans were not put in place to openly address these issues.

These issues constituted a breach in the legal requirements of the law. There was a breach of Regulation 9, 10, 12, 13, 14, 19 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we asked the provider to take at the back of the full version of the report.

Staff competency was not being monitored to ensure the training staff had was effective and staff were putting it into practice.

The service was responsive when people were unwell or if there was a change in their needs, requiring professional health support.

The registered manager responded to relatives complaints. There was a new registered manager who told us that they had been tasked by the provider to improve the service. They also told us that they had achieved this before with another service. The registered manager was involved in the daily running of the service and had connected to the people living at the home. The registered manager said they were committed to improving the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some people's rooms were cold.

The provider did not have a safe long term practical plan to ensure the home was warm.

The condition of the premises and the internal parts of the home required improvements to be made.

Staff knowledge about how to protect people from harm was not consistently good.

Recruitment checks on new staff were not consistently safe enough.

Is the service effective?

Requires Improvement

The service was not always effective.

We found issues with food and drinks. People were not involved with food choices. A regular supply of drinks was not offered to people.

Staff practice and knowledge was not being robustly monitored.

Staff knowledge and understanding with Mental Capacity was limited at times.

People had access to health professionals when they needed this support.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always kind and thoughtful towards people.

People's dignity and privacy was not always promoted and protected.

People were not always involved in the delivery and planning of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person centred care responsive to their individual needs.

People's social needs, interests, and achievements were not explored in a meaningful way, and on a regular basis.

The service responded to relative's complaints and concerns.

Is the service well-led?

Inadequate

The service was not well led.

We found multiple breaches of the Health and Social Care Act 2008.

Quality monitoring at provider level was not effective.

The culture of the service was not being reviewed.

There were no community links.

There was a registered manager who had been tasked to improve the service.

Ambassador House

Detailed findings

Background to this inspection

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

The inspection site visit started on 12 December 2017 and ended on 13 December 2017. The inspection was unannounced.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the expert-by-experience had personal experience of caring and supporting an older person living with dementia.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. We looked at the notifications that the registered manager had sent us over the last year. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with six people who lived at the home, and one person's relative, five members of staff, the chef and the registered manager. We looked at the care records of three people in depth, the medicines records of four people and the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home. We also reviewed the audits and safety records completed at the home.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in October 2016 improvements were required to ensure the service was safe. At the recent inspection in December 2017 we found that improvements were still required, but for different reasons.

When the inspection team visited Ambassador House we observed that some people's rooms were cold. The dining room was cold and as the morning progressed, the lounge was cold. We observed that people were wearing many layers of clothes. Some people were wearing thick jumpers and fleeces. One person was wearing a woolly hat. We went into one room where one person remained in bed all the time due to their physical and cognitive needs. We observed that this room was cold. We were invited into another person's room who was wearing many layers of clothes. They told us that they had to keep getting back into bed, because they felt cold. As we spoke with this person they did this. During our time at the home we noted that four people would generally mobilise around the lounge, but most people remained sitting for long periods. As we sat and observed people, staff, and looked at records, we also felt cold.

With the exception of one person all the people living at the home were living with different stages of dementia. This meant that these people sometimes communicated with us in ways which we could not always understand. However, when we asked people about how warm they felt those who could answer this question were clear with us. One person said, "My feet are freezing." This person was wearing a fleece jacket and a fleece lined thick cardigan. This person had socks on and took off trainers to get into bed. They said "I wish I had slippers. I had a wee fire there but somebody whipped it away." We noted that the radiator was cold. Another person said, "The home is cold. If you're cold it's miserable. I must get some socks. I've got boots on but I'm still cold."

The service had 17 degrees as the benchmark for a room being too cold. We believe this is too low considering the time of year and how vulnerable people were in the home. We consulted with the local authority about this, and they also felt this was too low a temperature.

We went into a person's room who was in bed all the time and unable to verbally communicate. This person's room was at 16 degrees. We brought the manager to their room. The radiator was lukewarm and a small electric heater that was attached to the wall was on. We noted that additional sealant around their window had been pushed into the closed window. This person was being checked on hourly but no action had been taken to address the temperature issue. We entered their room on the second day of our visit, their window had been left open and the room was very cold.

On the first day of our inspection we raised our concerns directly and clearly to the registered manager and took them to particular rooms which were very cold. We both checked the radiators in these rooms and commented on the fact they were either cold or lukewarm. The wall mounted electrical heaters were hot but the rooms were very cold. When we left after our first day we again expressed our concerns about the temperature at the home. We again took the registered manager to the person's room who could not communicate verbally, the room was very cold. It was at this point at 17:30 pm having had these

conversations since 11:00 am that day that the manager said, "I will instigate our emergency plan."

We addressed the temperature issues with the provider and operations manager. They sent us paid receipts from October and November showing us the work that had been carried out on the heating system. We were also sent information showing us that additional work was to take place after our inspection. The property was an old building with areas which were in need of repair to ensure people were warm in predictable cold periods during the year. For example, a bathroom window had been left open on the evening of the first day, and we closed it because it was so cold, noting that it did not shut properly. We noted dark water marks around a large period dome in the ceiling of the hall way above the stair case. The large hallway and stair case was continuously cold during our two day visit.

We shared our concerns with the local authority and raised a safeguarding referral. The local authority visited the home the day after our second visit. When they visited they found that on that day the home was warm enough. They subsequently visited again. They did not have concerns about the temperature of the home. We asked the provider to notify us if the temperature of people's rooms and the communal rooms fell below 21 degrees.

In addition to concerns about the heating system, we noted general repair issues throughout the service. We saw that people had side tables near them in the lounge. Some were broken. One disconnected from its base when it was gently lifted. One person's drink slid off another side table that was at an angle. This could be a risk to people scolding themselves on a hot drink. We also saw on two separate occasions' different people leaning on the arm of different chairs and the arms of the chairs came off. We entered a communal bathroom on two occasions, there was no natural light and when we pulled the light cord, the light was very dull. We noted that this room had been used by people. This could be a risk to people falling and harming themselves. We advised the registered manager about these issues.

When we went into people's rooms we noted that duvets were lumpy, the bed linen looked tired, and white towels had become discoloured to an off grey. One person's net curtain had a whole in it. We spoke with the registered manager about this.

During our visit we noted that one person's additional electrical heater in their room had not been tested since 2014 to ensure it was safe to use. We also told the registered manager about this.

From the recurrent failing heating system, and the broken and shabby fixtures and furnishings we concluded that there had been a lack of investment into the service by the provider.

During our visit we were invited into the kitchen by the chef, we were not invited to wear a protective apron. We observed two members of staff and the registered manager enter the kitchen and they also were not wearing protective aprons. We asked the chef about this they said, "I often have to remind them…and no they were not wearing them." This was despite the fact that protective aprons were available by the entrance of the kitchen. One member of staff serving people their lunches were not wearing gloves and we noted they were wearing nail varnish. This could be a potential infection control issue, and possibly cause a person to become unwell.

We found issues with elements of the hygiene of the home. People's side tables in the lounge were sticky. The legs to these tables had sticky spots and had a build-up of stains on them. Some bathroom's light cords were stained. In people's ensuites the shower heads and taps had a build-up of lime scale. The grouting between tiles were stained.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the home one person told us that their clothes went missing. They said, "I put my good clothes out and when I come back it's gone. I don't like that." We observed that the laundry basket in this person's room was marked with a number, which was not this person's room. The service was not protecting people's property.

We spoke to four members of staff about their understanding of how to protect people from potential abuse and harm. Two of these members of staff had a good knowledge of what abuse could look like and how to identify if a person was being harmed in some way. However, we spoke with two members of staff who had a limited understanding of this subject. One of these members of staff struggled to answer our questions at all and associated good hand hygiene as a way of protecting people from abuse.

Two members of staff were aware of the outside agencies they could also make contact with if they had concerns such as the local authority and the Care Quality Commission (CQC). However, when asked how they would contact these agencies, they were unable to tell us. None of the four members of staff we spoke with had noted the large 'safeguarding poster' in the hallway with the local authorities safeguarding team number on it. We were therefore not confident that they had the knowledge of these contact details. To have these agencies contact details is good practice and although the provider had ensured this information was available, they had not checked that staff were aware of it.

During our time talking with staff we asked how they protected people from experiencing harassment and discrimination. Two of these members of staff had a good and clear understanding of how to do this. One member of staff said, "It's not about treating everyone the same, it's about treating everyone as an equal." These members of staff identified 'Age' as a potential source of discrimination. However, the other two members of staff had no understanding of what constituted discrimination or harassment.

The above issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place which identified the risks which people faced, and included a plan which aimed to minimise these risks. However, these were not always up to date or completed in full. For example one person was living with diabetes; they had no plan in place to show staff how to manage this need. Another person had epilepsy, and although this was identified as a risk, there was no plan in place to show staff how to monitor and manage this need. We noted that some staff had signed to say they had read these documents. However, staff commented to us that these records were long. One member of staff said they had been at the home a few months and not read everyone's assessments and care plans. We did not see staff looking at these documents during our visit. We concluded that staff were not regularly looking at these documents for guidance or to ensure they were fully aware of people's needs and how to support them.

We asked people if they had to wait for support when they requested it. One person said, "They come and wake you, I press the bell when I'm ready and they take you downstairs." Another person said, "Yes they come." People were unable to tell us due to their memory issues if they had to wait long for support. The registered manager told us that the 'call system' did not allow them to analyse response times, but they had spoken with the provider about this. At present there was no concrete plan in place to rectify this issue. When we visited two people's rooms we noted that they did not have an option to reach or press the alarm bell to alert staff. A relative told us, "There are enough staff now. There used to be nobody around and some

[staff] were on their phones."

During our visit we looked at a sample of three staff recruitment files. None of these had full complete employment histories. Therefore, any gaps in employment could not be explained beyond the three years of employment history requested on the provider's application form. Staff had references but in one case a new member of staff had two character references rather than professional references. We addressed this with the registered manager who said one was from an employer. However, when we looked more closely it was clear that this was from a colleague the person used to work with. This referee had also provided a personal e-mail address not a work one. This had not been checked. The registered manager showed us that these members of staff all had Disclosure and Baring Service (DBS) checks. However, one of the three staff files we looked at only had one copy of the proof of their identity in their file. These are all important safety checks to ensure people are safe around staff. We concluded that the provider was not making competent checks to ensure these safety checks had been completed.

The above issues constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We completed an audit of people's medicines. We found some shortfalls of two people's medicines. After further examination and speaking with the registered manager we concluded that the amount of medicines delivered to the home from the pharmacy was less than what was recorded, on the medicines containers. An allotted member of staff had not checked the amount received when people's medicines were delivered to the home. The registered manager said this had happened before and they would speak with the pharmacy. Despite this happening before this issue had not been identified and addressed.

During this medicine audit we also found that one person had one less dose of one of their medicines. A senior member of staff said this had been accidently dropped that morning. However, they could not produce this discarded medicine or an incident report to reflect their account of events. We were later shown an incident form which the member of staff completed, the form stated they had informed the registered manager about this at 08:30 am, but they had not. We knew this because when we found this issue we spoke with the registered manager about this. They asked the member of staff in question to join our conversation. We spoke at length about this issue but the manager clearly did not recall the earlier conversation with the staff member, however, later that day the registered manager said they had forgotten this member of staff told them about this medicine issue. We concluded that a system of relying on individual staff members memory for managing situations when medicines needed to be discarded was not effective.

We noted that staff were taking the temperature of the medicine trolley. When we visited some people's rooms we noted that they had medical creams in their rooms. On their labels it recommended that they should be stored at no more than 25 degrees. Although the temperatures of people's rooms were being monitored it was not for the purpose of storing these medicines. Given the fact we found issues with the responsiveness of staff with the temperature of people's rooms, we could not be confident that this issue was being monitored and managed effectively during other times of the year.

As part of our medicine audit we looked at people's Medication Administration Records (MAR) and we cross referenced this information by doing a count of a sample of their medicines. We found that these people's medicines corresponded with the administration record signed by staff.

We looked at a sample of three people's incidents and accidents reports. From reading these documents it was unclear how the injury took place and what actually happened. In one incident it appeared if a person

in the home had assaulted another. The correct processes were not followed in this case. When we spoke with the registered manager about this incident, their understanding of the incident and the report did not match. Despite this the registered manager had signed this report to say appropriate action had been taken. The quality of the report was not questioned. Due to these issues we could not be confident that incidents were being appropriately managed to ensure people were safe and protective measures are put in place, following an incident.

When we visited the home we also looked at fire safety. We saw a variety of records evidencing various fire safety checks were being completed. This included regular fire tests and a recent fire drill.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in October 2016 we found the service was providing good effective care to people. At the recent inspection in December 2017 we found that improvements were required in this area.

During our visit we found issues with how the service supported people with their food and drinks. For example, we noted on one person's record that they had been admitted to hospital for dehydration in the summer. This person was at risk being too low in weight. A food and fluid chart was in place. However, when we looked at this there was no ideal amount of food or volume of fluids that this person should be consuming each day. There was therefore no course of action if the amounts fell below these recommended levels. We noted that there were three days in December that this person had not had their first drink until late in the afternoon. There was no explanation of this with actions taken. Most days this person was drinking two cups of tea and one juice. There was no evidence to say that this was being checked and if this was sufficient. We spoke with the registered manager about this who said they would investigate this issue.

The registered manager told us, and we could see in the provider reports, that staff had not always been filling out people's records. We considered that this person's apparent low intake of fluids could be an issue with staff practice in not completing documents. Equally it could be an issue of staff not meeting a person's nutritional and hydration needs. Both the registered manager and provider were not taking robust action to ensure staff were always completing these documents. In conclusion we could not be confident that this person's food and fluid needs were always being met and monitored effectively.

We observed lunch time and the lounge throughout the day. We noted that drinks were not routinely and regularly being offered to people. For example, a hot drinks trolley went round the lounge at 10:30 am. At lunch time most people were seated at 12:02 pm no drinks were given to people until 12:22 pm. After lunch people were not offered a hot drink until 15:00 pm. Snacks were not being routinely offered. One person at approximately 10:00 am said, "Can I have a biscuit." The member of staff said, "No biscuits now." Another person told us, "It was very strange coming here. Rules and regulations. Can't have a cup of tea whenever you want it."

In the late afternoon the administration person came to the lounge and started to ask people if they wanted anything. We noted they had not done this before. The first person they spoke with said, "I'll have a cheese and ham sandwich." This member of staff looked visibly surprised. They said, "You want a… sandwich?" This person said "Yes." This member of staff said "Ham and… cheese?" They said "Yes." This member of staff left the room telling a member of the care staff to do this. It was unclear what the purpose of this was as this member of staff or others did not ask everyone if they wanted something to eat and drink.

On the first day we visited there was only one meal option for lunch to eat and one pudding. We were told that two options were always on offer. We looked at the menu in the kitchen which had two choices for the main. However, the small notice board only had beef stew on it. With the exception of one person who ate finger food, everyone had the same meal. We asked one person what they thought of their lunch. They

shook their head and said, "No" making a grimace expression. We later asked them again and they repeated this answer.

The dining room was very cold which we had addressed with the registered manager. People's food did not look hot when they received their meals, there was no steam coming from the plated up food. Three people ate their lunch over the course of approximately an hour and staff did not ask if their food was hot enough. One person went to the toilet during lunch, when they returned they were not asked if their meal was hot or warm enough for them. With the exception of one member of staff, most staff did not ask people if they were enjoying their food during the lunch time.

This particular member of staff walked past one person at the end of lunch and asked had they enjoyed lunch. This person removed a large piece of beef from their mouth and gave it to the member of staff, because they could not chew it. One person struggled to eat their lunch and at times mistook the pattern of the table cloth for food. No support was offered to this person. It had not been identified if some people needed specialist equipment to eat their lunch.

During lunch time the TV was on at a loud volume. Staff did not ask if people wanted the TV on. Staff did not chat or engage with people but stood in between the tables. On two occasions we saw two members of staff watching the TV. Initially a member of staff started to give people their plated up meals saying in a stern way "Here you go." "Have that." They then noticed we were present and they said, "Here is your lunch sir." There was no audit of the lunchtime or evening meal experience to see if people were happy with their meal experiences.

We spoke with the chef on the second day. They told us how they tried to provide choice to people. There was a mixture of people from different cultural and ethnic backgrounds at the home. The chef explained to us how they tried to meet these different cultural needs in terms of the food people had to eat. However, people were not being involved generally in a meaningful way with what they ate and drank. People were asked in the mornings what they wanted to eat from two choices. There were no pictorial menus in use. The food board was small and written using faint pen. There was no checking process if people still wanted to eat what they had chosen.

When we asked people about their views of the food and drinks provided, we had a mixed response. One person said, "It's quite nice. I can eat anything at all." Another person said, "It's not bad. Yeah (there's plenty of it). No choice, it's usually set things. A further person said, "Not everything is good but yes I do enjoy dinner."

The above issues constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had told us that all the staff with the exception of one had been replaced since they took the role of manager. They said that this was because there were issues with staff practice and the culture of the service. Therefore most staff had been in post from May 2017 onwards .

Staff spoke positively about their training and their inductions. New staff shadowed other members of staff including a senior and the registered manager. During this time staff completed training in health and safety and moving and handling delivered by the registered manager. They later completed on line training in other areas such as safeguarding, mental capacity, dementia, and first aid. However, there were gaps in this training. We were shown a training matrix which showed that not all training had been provided. For example there were two people living with diabetes at the home and only one member of staff had received

training on this subject. Five members of staff had not completed their safeguarding training. Ten members of staff had not received training on Dementia and yet the registered manager told us, "This is a dementia home." There was no dementia lead, and good practice in relation to dementia care was not promoted in the home.

During the inspection we observed issues with how staff performance in relation to how they responded to concerns about the temperatures in people's rooms, people's care needs and their social needs. Some staff we spoke with had a very limited knowledge about discrimination, and abuse. We asked one member of staff about discrimination they said, "I haven't had training on that yet."

There was a lack of competency checks taking place to ensure staff were effective in their roles. Staff practice, other than medicine administration, was not being routinely checked against a robust competency check list, and evidenced. When new staff completed their induction there was no evidenced competency check to test if a member of staff was ready to start working independently. Staff were not being asked key questions in their supervisions to test their knowledge. We spoke with the registered manager about this who said they were planning to introduce these systems but had been unable to do so yet, due to the level of work required at the home.

The premises of the home were not designed in a way to help support the needs of people who were living with dementia. Specialist equipment was not used to support people who were living with dementia.

There was no separate space for people to access from their rooms for more private time with relatives or one another. There was a small visitor's room which was extremely cold until a heater was placed in it. The 'activities' room was used as a staff room. There were coats and handbags in this room, a microwave which had food debris on it, and some equipment to support people to transfer from one position to another placed into one of the corners of this 'activity' room.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with three members of staff who had a good understanding about what mental capacity meant. These members of staff were able to give examples of how they asked people about elements of their daily living needs. They also said that they respected the wishes and choices that these people made. Two members of staff were also aware of the processes that must be followed if a person does not have capacity to make a particular decision.

One person had been placed under a DoLS by the local authority due to the risks they faced if they left the home alone. Staff told us that if people wanted to go out they advised the senior or registered manager and went out with them. However, we spoke with one member of staff who did not have a clear understanding about mental capacity. Two members of staff did not understand when a DoLS would be put in place. We

noted that not all staff had completed their training in these areas. We concluded that further work was required to evidence the service and staff were always compliant with MCA and DoLS.

When we visited the home on the second day we noted that a person looked unwell. We observed staff responding to this by talking to the registered manager. The registered manager told us about another person who they felt had a bad cough. We later saw a community nurse visit to assess this person's needs. We later heard the registered manager informing staff that they had spoken to the GP about the other person's health and what initial action was to be taken to help them get better. When we looked at people's records we could see the GP and other specialist health professionals had been contacted.

The registered manager told us that no one had pressure ulcers at the home and what actions they were taking to prevent the development of pressure ulcers. The registered manager and deputy manager had recently joined a health initiative to prevent pressure ulcers in care homes. The deputy manager was completing this training when we visited the home.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in October 2016 we found the service was providing a caring service. At the recent inspection in December 2017 we found elements of how people were being supported which was not caring.

We saw a person who was living with advancing dementia have their lunch. This person was not eating. We saw a member of staff sit next to them and they tapped them on their upper arm to gain their attention. This looked abrupt. On the second day a member of staff was supporting this person to eat their lunch. This person was not eating their meal. The member of staff got up and left the person, leaving the lounge. After a while a member of staff said to another member of staff, while pointing at this person, "Is she not eating?" They then started to support this person to eat. They had also not checked if the food was warm. These two members of staff made no attempt to have a conversation with this person or explain what they were doing. This was not a respectful way to support this person.

During our visit we heard staff refer to people amongst themselves near or in front of people as "She" or "He". They did not always use the person's first name or involve them in the question they were asking about their care.

On the first day of our visit a person who was sitting in the lounge indicated they wanted support to use the bathroom. A member of staff supported them to go to the bathroom. However as this person stood up their skirt and underwear loosened, exposing part of their body. This member of staff tried to pull their top down, but it would not reach. This person then walked with this member of staff across the lounge. This member of staff only took practical action to promote this person's dignity before they exited the room, by stepping behind them. This left the person exposed and did not protect their dignity.

We saw two different members of staff apply medical creams to people in the communal spaces. On one occasion this involved one member of staff apply a cream under a person's blouse while they were waiting for their lunch. Another time a member of staff was seen to be vigorously applying a cream to a man's face. The members of staff did not ask if these people wanted their creams applied in public spaces. They did not attempt to promote these people's dignity or privacy.

When we asked people about how staff promoted their privacy we had a negative response. One person said, "Some of them [staff] walk into my room." Another person said, "They knock and walk in, no patience." We asked this person if staff drew the curtains when providing care. This person said "No, a couple of times I've had to ask them to." This did not demonstrate respect for people's privacy.

We observed that people's private information was not always stored securely. In the lounge on both days we visited people's daily notes were piled up in the corner. This was to enable staff to update people's daily notes. This did not prevent records from being looked at by anyone else who entered the room. Two people sometimes spent time in the manager's office. On one occasion we saw one person looking at another person's records, and on another occasion we saw a person in the lounge looking at a person's daily notes

while the member of staff was updating them. We spoke with the registered manager about this, who said that these people would not be able to understand this information contained in these records. We explained the service should be protecting people's private information.

The above issues constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked people if staff were kind and caring towards them, we had a negative response. One person said, "Well, mostly." Another person said, "Sometimes they're [staff] not nice." We asked whether staff are ever unkind and they said, "Sometimes, I have to say." A relative told us, "Most of them (are kind and caring). There is one I'm not too….you know, could be more caring in how they handle people."

Despite the negative observations we did see some staff treat people in a kind way. We saw one member of staff put their hands on a person's shoulder and gently rub their back. We also heard a member of staff pay a compliment to one person about how they looked. However, these observations were in the minority.

The lack of a timely response by staff, the registered manager and the provider in relation to the cold temperature of the home was not caring. People who were cold were not effectively assisted by staff

One person kept trying to zip up their fleece jacket. On three occasions they kept trying to do this when they were near staff. The zip was broken and staff kept telling this person to leave the zip alone. One member of staff said, "leave it, ok man." No one took practical action to offer this person a different fleece jacket to wear. We spoke with the registered manager about this and we saw them instruct a member of staff to help this person to change this jacket. However, we needed to prompt this before practical action was taken.

People were not always being involved in decisions which affected them. During our visit we observed three different members of staff speak with two people about their care. They did not explain the situation and try and rationalise with them. For example, two members of staff wanted a person to move from the dining room to the lounge, because it was cold in the dining room as a member of staff had turned off the additional heater in this room. This person was watching a film. They said they wanted the person to go to the bathroom, but the person said they did not want to go. They kept lifting this persons arms up as an attempt to encourage them to mobilise. Eventually they asked if the person felt cold, when they answered "Yes" they agreed to go to the lounge.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in October 2016 we found that the service was not responsive to people's social needs, people said they felt bored. At this inspection in December 2017 we found that improvements were still required.

When we visited Ambassador house we found that the care and support people received was not always person centred and responsive to people's needs.

A member of staff came to sit in the dining room. From across the room they asked one person if they were ok. This person had a hearing impairment and could not hear this member of staff. When they spoke with this person they shouted at them. Good practice would have been to go over to the person and speak with them. During the time this member of staff sat in this room, their arms were folded. They had not considered how their body language looked. We later spoke with them and the registered manager about this. After this conversation they said, "I was cold, that's why my hands were under my arms."

During our visit one person asked a member of staff if they could go out. The member of staff said, "Maybe later." They did not explain to the person that it was icy outside and it had snowed recently so it could be dangerous. They did not offer to check the weather conditions for the next day. No real practical plans were made to make their request to go out, happen.

We observed that a person was scratching their head and their arms repeatedly at approximately 11:00am. A member of staff said, "Are you alright?" The person replied, "No it itches, not very nice." This member of staff offered no solution and walked away. This person continued to itch and later this member of staff said, "Do you want some cream?" However, no cream was provided. Later again when this person was in the in the dining room at 12:02 pm, they were still itching. Staff were present but did not respond to this need.

During our two day visit we looked at a sample of three people's care records. People's needs were identified but there was sometimes a lack of information which fully reflected and explored their needs. One person, for example, was unable to verbally communicate. There was no clear information recorded about how this person expressed they were in pain, unwell, or cold. This person had epilepsy; there was no information or consideration to direct staff to the possibility that they were having a seizure. When we spoke to the registered manager about this, they told us how this person expressed discomfort, but this was not recorded. There was no evidence to say this person's communication needs and symptoms of a seizure were fully known by the care staff at the home.

Despite these shortfalls we noted that people's care records did contain some personal information about people's backgrounds, interests, and some personal preferences. However, this was limited in detail, often family and friends were involved in people's lives, but further information had not been obtained. For example, one person's record stated they liked documentaries, what type of documentaries was not

mentioned. One person liked reading the newspaper, but it did not say what type of newspaper.

When more detailed information was present staff were not always making use of it in order to meet people's social needs. One person liked a particular type of music and was in a band when they were younger. Over the two days we visited the home this music was not being played in their room. Instead, daytime TV programmes were playing. In this person's notes it stated what activities they were doing; it always stated "Watching TV." This person could not verbally communicate and no efforts had been made to promote their life long interests and involve other people in this process.

We asked people about whether there were enough social activities in the home. One person said, "I get sleepy just because there's nothing else to do." Another person said, "When you're sort of packed together it's a bit difficult. It's different if you can go out." We asked what happened if they wanted to go out and they said "You don't. I usually sit in the chair and nod off. It's 2 or 3 hours out of the day. I would choose a short walk."

On the first day we visited the home the 'activity co-ordinator' could not attend work. This role was not replaced. No activities took place that day. People spent most of the time asleep. On the second day we were at the home, in the afternoon an art and crafts activity took place . Generally we observed that staff did not engage with people in a social way. With the exception of two members of care staff, who spoke with two people in passing, staff did not chat or spend time sitting and talking with people. We observed that there were times when staff had the opportunity to do this, but they did not. For example, at lunch time, we saw staff watching a TV programme. A person was being supported to have their lunch, but the staff who did this did not speak with this person. During the morning we saw staff standing and over seeing the room, one of whom was inspecting their own nails. We concluded that staff did not know how to engage with people who were living with dementia and they did not utilise clear opportunities to talk to people.

The TV was on in the lounge on a continuous loop of a day time TV channel. People were not asked if they wanted to watch something else. No conversation was initiated by staff about particular programmes. Some people sat beneath the TV and could not see it. On one occasion a member of staff said, "Let's put some music on." However, they did not suggest any particular types of music to try and engage people with this idea. One person in the lounge used to sing a particular type of music, but this type of music was not suggested.

When we looked at people's activity records there were large gaps in these records where nothing was recorded. We noted there was an activity planner and we could see from an incident report that there had been a trip out, for a small group of people. When we asked staff what they did if people said they wanted to go out, staff told us that they took certain individuals out to the park or for a short walk. However, considering the diverse ethnic background of people living at the home there had been no attempt to consider what support was available locally. The registered manager, provider, and staff had not considered creative ways to stimulate people and connect them with their interests they had before they became unwell.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints process and we could see that the registered manager had responded to some complaints raised by relatives. However, in their response to these complaints, the registered manager had not sign posted to the complainant what they could do if they were not happy with the response to their complaint. Although, we were told that the registered manager advised people who lived at the home and

their relatives about the complaints policy at the 'residents and relatives meetings.'

People told us that they would inform the office staff if they had a concern. We spoke with a relative who told us that the registered manager responds well to any issues they raise with them. This relative said, "The Manager reacts well. They tell me what they are putting in place."

When we looked at people's care records we could see that people had 'end of life' plans in place. These detailed who was involved in these people's lives and how to contact them. However, there was limited information about how and where people wanted to spend their last days. What options were available to them and whether these had been explored with the person was not evident from looking at these records. People's religious faiths were considered but what this meant in practical terms in relation to the end part of their life was not documented for staff to follow. There was a lack of personal information regarding people's wishes and feelings about how they wanted their life to be celebrated when they died.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in October 2016 we found that there were two areas of the service which required improvements. The home was rated as requires improvement overall. At this inspection in December 2017 we found that further improvements were required.

When we visited Ambassador house we found multiple breaches of the Health and Social Care Act. We found fundamental issues with the heating, and there was a lack of responsiveness at all levels. The registered manager, the care staff, and the provider to adequately address this issue. All were aware there were historic issues with the heating system. There was no long term plan to address the heating. There was no robust contingency plan in place. Staff had not been advised and trained about how to maintain a good temperature in the home. There was no quick robust system in place when staff identified an issue with the temperature in people's rooms and in the communal parts of the home. The baseline for the temperatures in people's rooms was too low. We needed to prompt action. Therefore we did not have confidence this issue was being robustly managed by the provider and the registered manager. The provider's quality audits had not identified this issue from their visits.

We were so concerned that we made contact with the local authority contracts team who monitors residential services. We also raised a safeguarding referral to the local authority safeguarding team about the person whose room was consistently cold and could not leave their bed. The local authority visited the next day after our inspection. We later spoke with the provider and asked them to evidence the work they had carried out on the heating system and to respond to our concerns. They agreed to inform us if the temperature of the home dropped below 21 degrees.

Some people's rooms were in a poor condition. We found issues with some of the furniture in the communal parts of the home. Paint work was chipped in places and there were potential hygiene and infection control issues identified. One person said, "It (the home) needs a fix up. I worry about it. I like to see things done properly. It's not nice." There was no clear and detailed improvement plan created by the provider and registered manager. When we asked to see this, the plan we were given was a general maintenance plan. When we addressed the condition of some people's bed linen we were told by the registered manager the linen was new, but this was not the case. The provider's quality audits had not identified these issues of the general maintenance of the home.

People's social needs and aspirations were not being considered or addressed. What people found interesting and their past achievements were not being promoted or celebrated by the service. The provider had completed quality audit visits but had not identified this issue. At times throughout the inspection people's dignity and privacy was not being promoted by the staff.

People were not being consistently treated in a kind and caring way. People had limited choice with food and drink, and their dining experience was not meaningfully considered. One person said their clothes went missing. People felt there was little to do. People were not being consulted with about their experiences with staff and what they wanted to do each day.

There was limited quality monitoring taking place by the provider. The culture of the service was not being assessed with a set of targets to reach, despite the registered manager having concerns about the culture of the home when they started in their role. There was no shared identified values and understanding of what good quality care looks like. Staff competency was not being monitored in a meaningful way to promote improvements.

We found shortfalls in how accidents incidents and medicine issues were being reported by staff. The registered manager had signed to say appropriate action had been taken in these incidents but it was unclear from reading some of these reports, what had happened and whether appropriate action had been taken. The registered manager gave us a verbal explanation but their account was totally different to the reports account. The provider had not fully reviewed these documents spoken with the registered manager and identified this issue to improve the reporting of incidents. To enable transparent investigations into incidents to try and prevent them from happening again.

The registered manager told us that the home was a "Dementia home." There were no attempts made and no experts in this field consulted with to support the service to fully meet the needs of people who were living with dementia. There was also a lack of a community involvement and initiatives to involve the community. Considering that most people were living with advancing dementia the registered manager, provider and staff were not advocating on people's behalf to ensure they did not feel isolated, bored, and they had a sense of belonging. Creative ways to re-engage people with life long interests and beliefs were not made, despite the fact that at some point, these interests and beliefs had been identified at people's assessments.

The registered manager told us that when they took up their role at Ambassador House they realised that in order to improve the service and make it a good home there was a "Lot of work to do." They said that they had been brought into the home by the provider to make improvements and that they had a work history of doing this. However, there was no action plan developed which detailed when, what, and how improvements would be made, and by whom. The provider had not facilitated this and the registered manager had also not produced such a document. Therefore it was not possible to identify what action they intended to take or what progress had been made.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the registered manager was hands on and involved in the daily running of the home. The registered manager had got to know people at the home and formed relationships with them. All the staff spoke positively about the registered manager. We could see that staff meetings took place and there was a 'relatives and residents meeting' planned. The registered manager said they were committed to the home and to make it a 'Good' home.

The registered manager was aware of the type of events they must notify us about by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person-centred care. The provider had failed again to ensure that people had personalised support to meet their social needs and preferences. Regulation 9 (1) (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and Respect. The provider had not ensured that appropriate action to ensure people are always treated with dignity and respect. Regulation 10 (1) (a) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks.

Regulation 12 (1) and (2) (a) (b) (d) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment. The provider had not ensured that appropriate action was taken when safeguarding events took place. Regulation 13 (1) (2) and (6) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA 2008 (RA) Regulations 2014: Meeting nutritional and hydration needs. The provider had not ensured that appropriate action was taken to ensure people's nutritional and hydration needs were met. Regulation 14 (1) (2) (a) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the safety of the service provided and to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This also included the management of the service.

	Regulation 17 (1) and (2) (a) (b) (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (RA) Regulations 2014: Fit and proper persons employed. The provider had failed to ensure that appropriate safety checks were carried out to ensure those employed were fit to carry out the regulated activity. Regulation 19 (2) (a)