Ideal Carehomes (Number One) Limited

Ashworth Grange

Inspection report

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Date of inspection visit:
27 June 2016
28 June 2016

Date of publication:
01 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Ashworth Grange took place on 27 and 28 June 2016. Both days were unannounced. This was its first inspection under the new registered provider of Ideal Carehomes (Number One) Limited.

Ashworth Grange is a home for people needing assistance with personal care, some of whom may be living with dementia. The home has 64 places and on the day we inspected 47 people were living in the home. The home has four separate areas, two of which specialise in caring for people with dementia.

There was a registered manager in post and in the home on the days we inspected. 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.

We found that staff knew what may be regarded as a safeguarding concern and how to report these. People and relatives said they felt safe.

Risk assessments were person-centred in their recording style but lacked basic information regarding the method involved in using equipment if this was needed. This meant staff did not have the necessary guidance to manage risk effectively and minimise the chance of harm.

Staffing levels were not always adequate. We observed periods where staff were frequently changing between units. This meant they did not always know everyone or what the key concerns were for that person that day. Both people in the home and relatives mentioned this to us and said there were periods when they had to wait or when communal areas were unattended as staff were supporting with personal care. Call bell logs illustrated this and the lack of analysis as to whether there were any particular periods where pressure was higher masked the issue.

We observed medicines being given to people patiently and supportively. However, we had concerns regarding storage as one of the trolleys had a broken lock and could not be left unattended, thereby restricting another member of staff to overseeing this if the medicine administrator had to attend to a person out of the room. Keys were also left in all cupboards meaning that access to medicines in the treatment room were not restricted to authorised personnel only.

Staff did not always follow necessary infection control measures as we saw bedlinen being handled without appropriate protective clothing and interaction between a staff member and other person in the home again, without appropriate protection despite the staff member knowing the person had an infection.

People and relatives spoke highly of the food and we saw staff support people to eat and drink well throughout both days. However, further detail needed to be recorded on the food and fluid charts to enable

accurate analysis of any weight loss.

The registered manager and staff had a basic understanding of the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards. The home had applied for appropriate authorisations.

Staff had ensured all their training was current and were being supported in their roles by reflective supervision.

People were supported to access other health and social care services as they needed them, and necessary records were kept which were included in people's care plans.

Staff displayed kindness, friendship and patience in their interactions with people, and it was evident they knew people well as some staff were working on the same units.

There was a range of activities on offer for both groups and individuals. People were able to join in a variety of events and equally were able to enjoy time in their rooms.

Care records had been written in a person-centred manner, reflecting people's specific needs and staff demonstrated knowledge of these.

The home had a positive atmosphere with evidence of engagement and staff felt supported. We saw staff meetings were structured and feedback was considered. However, audits had failed to tackle some of the issues we found.

We found breaches in Regulations 12 safe care and treatment, 17 good governance and 18 staffing. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People and relatives told us they felt safe and we found staff understood how to respond to possible safeguarding concerns.

Risk assessments were not person-specific in relation to moving and handling requirements.

Staff were under pressure and were changing between units frequently on both days we inspected. People and relatives told us they sometimes had to wait for staff to assist with personal care.

Medicines were given to people sensitively but storage was a significant risk and administration in some units was not in accordance with best practice.

We saw poor practice in relation to infection control.

Is the service effective?

Requires Improvement

The service was not always effective.

We observed staff encouraging people to eat and drink throughout both days but food and fluid charts did not always contain meaningful information.

The registered manager had applied for DoLS for people whose liberty was restricted.

Staff had received reflective supervision and training, and this was evident in the conduct of most staff we observed.

People had access to health and social care professionals when required.

Is the service caring?

Good

The service was caring.

Staff were patient and knowledgeable in their approach with

people, providing reassurance and distraction where necessary.

We saw consent had been sought from people and their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had access to a selection of activities, both communally and individually, and we saw staff make an effort to engage people.

Care records were person-centred and reflected most people's needs accurately.

Complaints were handled in a timely manner and lessons learnt were shared with staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home had a positive atmosphere and people appeared happy and relaxed.

Staff felt supported by the registered manager who in turn received support from the regional manager.

There were significant issues that had not been identified or addressed through the quality assurance systems in place.

Ashworth Grange

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 27 and 28 June 2016 and was unannounced on both days. The inspection team consisted of three adult social care inspectors and an Expert by Experience on the first day, and two adult social inspectors on the second. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with 15 people using the service and 12 of their relatives. We spoke with 12 staff including one senior carer, six carers, two members of the kitchen staff, the front of house manager, the registered manager and the regional manager.

We looked at 16 care records including risk assessments, three staff records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

One person we spoke with said "I do feel safe living here as I know there's always someone around." Relatives told us they felt people were safe in the home. One said "Our relative is now in the safest place. We have no worries." Another relative told us "I have an absolute confidence that they are safe and well cared for 24hrs a day." The visiting nurse said "I feel that all the people here are in safe hands." Staff were able to explain what may be a safeguarding concern and knew how to take appropriate action. One staff member said "I've never had to report any colleague but would feel confident to report if necessary." Another staff member said "I would have my own relative here." The registered manager was reporting safeguarding concerns as required under the regulations.

We asked people living in the home how quickly their needs were responded to. One person told us "I have to wait a long time for staff to do things" and another said "The staff work very hard. They do get busy. They ask me to wait a bit." A further person said "The night staff look in on me - they just pop their head through the door" which they found reassuring. We found one person in bed at 9.30am who told us they were not sure what time they would be getting up. They said "I have to wait. I can buzz and they answer that but then give excuses. They tell me 'I'm doing breakfast'." We were told later by the registered manager that this person 'likes to stay in bed'.

Relatives had a mixed view. One said "If my relative calls for help via the red button - the staff come" and another said "It looks to us as though there are enough staff." However, other relatives told us "The staffing improved a few months ago - it has dropped off now" and another said "One day there were only two staff on duty in this area and they were both new staff. They did not know my relative's needs." A further relative said "Some people take two to care for and hoist. If there are only two staff on, who is supervising the rest?"

We found that staffing levels were set with two staff on each of the four units with one 'floater' over the whole home who could provide support when needed in any unit. The home used a dependency tool and told us that staffing levels varied according to need but we did not see evidence of this in the staffing rotas. The registered manager advised us that staffing levels were reviewed monthly after discussion with the regional director. However, we saw in the regional director's report from May 2016 that staffing levels were linked to occupancy rather than people's level of need.

On the first day we inspected three staff had phoned in sick and the registered manager had covered two of these shifts with staff who usually provided domestic support. We were shown they had received the same training as the usual care staff and did appear to know the people well. One of these staff was later replaced with a carer from another of the provider's homes who had been asked to cover the remainder of the shift. However, they did not know any of the people in the home and had the briefest of handovers which we observed which meant they were not able to provide effective cover. They were unable to say how many people were on the unit nor which staff they were working with.

A further carer was providing support in the kitchen despite having to bring her child to the home as they had advised the registered manager it was 'a teacher training day they did not know about until arriving at

school.' This same carer was working on the second day of inspection due to a lack of staff and their child was in the home again. We asked the registered manager about this, advising them of the inappropriateness and they assured us the child was not ill but that the carer had to work as there was no one else to cover. This child was only there for the first part of the afternoon.

The staffing levels meant that if people required two staff for personal care the unit was potentially left unattended, or with the one 'floating' member of staff if they were free. The floating member of staff needed knowledge of all people's needs in the home at any one time as they could be requested to support anywhere. We also noted this one 'floating' member of staff was actually responsible for doing the medication rounds on one of the floors the day we inspected as they were the senior carer so were not free for considerable parts of the day as this took precedence. The other medication round was covered initially by the front of house manager and then by the deputy manager who was covering for a sick staff member.

We asked staff their opinion of staffing levels and were told by one "We have two per unit and one floater plus laundry and a cleaner. I feel this is manageable. If I need to leave the unit the floater will support." They also said they were not often called upon to do extra shifts and that the home never used agency staff. We were unable to complete their staff interview as they were needed to support the other carer with assisting a person out of bed at 11.45am. This was the person's choice but showed that the unit was stretched as the floating staff member assisted the regular carer with this task while the cover carer began preparations for lunch. During lunch the registered manager had to serve dessert to people as the two care staff were supporting someone with personal care and no other staff were free to support.

At 9.50am two staff (one of which was the floating staff member) on the downstairs dementia unit went on their break leaving one staff member. When they returned the remaining staff member went on their break. However, they had not returned by 10.30am and so the one staff member had to request assistance from another unit to help transfer someone to their room for attention by the district nurse. However they were advised they needed to wait for ten minutes as no one was available. This meant a delay for the person needing to receive care and for the visiting nurse. On the second day of inspection we again observed staff having to request support from other units while they assisted people who needed two staff to support. Although this meant the home was not leaving communal areas unattended it was putting strain on the unit which had been left with only one member of staff and meant staff were less able to respond to any issues.

Close analysis of the staffing rotas revealed that staff were allocated many different roles between caring, laundry and kitchen support. This included one of the senior carers working in the kitchen on some days which did not seem a sensible use of their skills. This swapping between roles meant a lack of continuity for people in the home and although the registered manager was trying to keep people in the same units this was not always achieved. We noted staffing levels had varied between nine and ten for May 2016 on the rota each day but their tasks changed frequently.

The registered manager informed us they had begun closer scrutiny around the time taken to answer call bells. This involved keeping a log of all calls that lasted longer than seven minutes. We asked to see this information and found that although all calls over seven minutes had been logged only three had been looked at to see what the issue had been. Between 9 May 2016 and 22 May 2016 147 call bells were left unanswered for over seven minutes. Over one weekend there had been 52 calls like this. We checked the staffing rota to see if this was a concern but saw that all shifts had been covered and the registered manager did not indicate any concerns in staffing levels over recent weeks. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's needs were not met in a timely manner and there did not appear to be any corrective action taken to remedy this.

We looked at staff recruitment files and found the home had carried out appropriate checks ensuring references were obtained and Disclosure and Barring Checks were completed as required. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Upon our arrival in the home we noticed a person had both of their legs bandaged and these were blood stained. We asked staff what care was being provided and one staff member advised us that "The person has an infection. We are getting the district nurse in today." We later saw one staff member in the person's room stripping their bed and the bedsheets taken to the sluice. The staff member wore a pair of disposable gloves to do this. There was no signage on the person's inside door to indicate the high risk of infection. However, on their return they entered a different person's room, asking if they wanted to get up and when the person replied yes they started to get some clothes out of this person's wardrobe. They were still wearing the same pair of gloves.

We asked the member of staff if they had been aware of risk of cross infection. They said 'yes' but when asked why they had not then changed their gloves, they replied "I haven't touched the other person yet." This answer showed a lack of awareness and regard of infection control. This staff member was covering for a sick colleague and was not usually a carer, however, the registered manager advised us that all staff had received the same training so they could interchange their roles. Later we observed the same member of staff removing soiled laundry from the room of someone with a stomach upset but this time they were not wearing any gloves despite the plentiful supply of protective personal equipment in the nearby bathroom. This example posed a serious health risk to people living in the home due to lack of effective infection control. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the home was not ensuring the risk of infection was reduced.

One person told us "The staff take care of all my medicines. They give them to me on time, and extra ones if I need them in the night." A relative advised "If my relation asked for extra pain killers, they come immediately." A visiting nurse told us "All the equipment and supplies I need are in stock." Despite these positive comments we noted that the morning medication had yet to be administered by 10.10am in the downstairs dementia unit. The staff member said "There's medication being given upstairs first." We asked what time the morning medication round usually occurred and were advised "it varies." The medicine trolley arrived about ten minutes later and medication was given by the front of house manager who we checked had received the necessary training. No times were recorded on the Medicine Administration Record sheet apart from pain relief medication. Rounds were divided into morning, noon, tea and bed. However, due to the lateness of the morning medication round in one unit this could have impacted on the time people were due to take their lunchtime medication as people were still receiving their morning medication at 11am.

We observed medication was administered patiently by members of staff. They supported people to take their medication at their own pace, explaining what each medicine was for and why it was important to take them. One person was asked their consent prior to receiving eye drops. Another person complained of a headache and we observed staff speak to the deputy manager for some pain relief for the person which was duly given. The registered manager advised us that all staff had completed their medication training and records confirmed this. In addition, medication competency checks were carried out by the registered manager and deputies over three separate shifts and we saw these had been completed. Stock levels tallied with what had been received and administered and controlled drugs quantities matched records.

In the upstairs residential lounge the staff member administering medication asked another member of staff to 'watch the trolley' while they left the room. We saw the trolley was not locked and loose medicines were on top of the trolley in their original packaging. This contravened the home's policy which stated 'If you

leave the trolley unattended, ensure it's locked at all times. Never leave or ask another person to watch the trolley for you.'

We also saw the Medicine Administration Record (MAR) was signed at the point the medication was removed from the blister packs and prior to the person actually having received their medication. This was against the home's own medication policy and does not follow expected practice. Multiple medication pots were prepared at the same time heightening the likelihood of medication being mixed up. Although the staff member was wearing gloves, these were torn and their uniform was not properly zipped at the front, posing an infection control risk.

We checked the downstairs clinic room and found the medicine trolley was unlocked and still had morning medication in a tray on the top of it. In addition, despite a notice saying 'please make sure all cupboard doors are locked' they were all open with the keys in them. We spoke with a member of staff as to why the medicine trolley was not locked and was advised the lock was broken and had been for about two weeks. We spoke with registered manager about the potential security risk and they advised they had contacted the chemist to request a replacement but could not provide us with evidence they had done this. They chased the chemist while we were there.

We checked the upstairs clinic room on the second day of inspection and found the keys were kept together for both trolleys meaning if they were lost people would not be able to access their medicines, and they were also on top of the trolley. As with the downstairs room all cupboards were unlocked with keys in each door. Although the clinic rooms were locked this meant any member of staff whether authorised or not could access the medication. This is a further breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not being managed safely or properly in all cases.

We checked the first aid box on one unit and found only four triangular bandages, one small adhesive dressing and a pair of gloves. In a different unit, there were eight triangular bandages and one sterile dressing which had expired in September 2015. We were advised by the registered manager the checking of this was assigned to the front of house manager who had recently retired and so the registered manager agreed to restock these immediately as they were unaware of the issue.

We checked all fridges as we found the frozen compartment was all iced up in one unit and could not be opened. Four yoghurts were out of date - two were dated 21 June, six days prior to our visit. This posed a significant health risk which we discussed with the registered manager. They agreed to remove the out of date products immediately. Temperature checks were also sporadic with the last entry for one being 3 January 2016. The registered manager advised us that this was the responsibility of the kitchen assistant but there was currently a vacancy being covered by care staff. In another unit the fridge was dirty and had uncovered beans, soup and a further out of date yoghurt, and the fridge in the upstairs dementia unit had the handle coming off which we later saw reported to the maintenance team to fix. This lack of scrutiny meant the registered provider had failed to protect people from the risk of food poisoning. On the second day we noted all fridges had been cleaned but still found food uncovered and undated in one fridge. This is a further evidence of a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as appropriate care had not been given to emergency supplies or to the checking of food to ensure it was being stored properly.

We asked the registered manager how they assessed risk. They advised us "that all staff had signed them" and showed us records kept in their office relating to generic home risk assessments.

We looked in care records at risk assessments. In one care record it was noted '[Name] has no mobility

anymore. They are in a profiling bed all the time. If [name] needs to be moved this would require two carers, medium sling and hoist.' This was evaluated monthly but gave no more guidance to staff as to how to safely move the person. Contained in the person's record was a document entitled 'Hoisting Principles - how to use a hoist'. However, this lacked the level of detail required for safe transfer just referring to 'using the appropriate sling for the hoist' with no specific instructions pertaining to that individual. Their file also contained the manufacturer's instructions in relation to the hoist. One person, who remained in bed as movement made them feel ill due to their condition, had procedures in place for moving and handling them in bed including pictorial guidance. However, there were no specific hoist instructions relating to which sling or loops were to be used.

We observed one person being moved in a hoist and although staff took care to ensure the person did not bang their head on the hoist bar when being lowered into the chair, they did not ensure the person's dignity was preserved as their clothing had ridden up. We also saw one person in the home in respite who had a plaster cast on their leg from their hip to their toe. They were hoisted out of bed but we could find no evidence of a specific moving and handling risk assessment despite the obvious issues with an immobile and weighty limb. We asked the registered manager who had completed an assessment and they advised us "they were assessed in hospital and they came with a sling from there." When we asked how the staff were sure the sling was the right one the registered manager said "The care staff assessed her." This meant that a person specific risk assessment had not been completed by appropriately trained staff as care staff were only trained in moving and handling techniques, not which equipment a person should be using. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered manager had not ensured all directions for use of equipment were in people's care records showing person-specific assessments.

We looked in another person's record and found a completed falls risk assessment which indicated they were at medium risk of falls. According to the records this meant the person should have had a risk reduction plan in place along with regular monitoring. We could not find either of these two documents showing that the home had not ensured all measures possible had been taken to reduce the risk of falls. However, we did note they had responded to a letter from the physiotherapist received in February which showed they had followed up our concerns from the previous inspection. We also observed a staff member encouraging this person to sit back in their chair as "I don't want you to fall" showing that staff had an awareness of the high risk. We observed on more than one occasion staff intervene if people decided to walk without their walking aids.

The registered manager told us they had mapped all falls, logging the time of the fall. They said since they had increased staffing to five people at night falls had fallen in this period. We could not see any detailed analysis to evidence this as the data had not been totalled or analysed in relation to unit incidents. All falls were reported to other agencies as the need arose and actions taken as recommended by these other professionals. However, the home was having a high number of unseen falls averaging 28 per month between February and June 2016 and the spread appeared even across the home. Information was analysed in relation to specific individuals and all accident reports completed in full, signed by the staff member and the deputy.

Each unit had its own handover notes which highlighted significant factors for people such as illness, requiring two staff for personal support or medication changes. These were completed in most units with relevant information. This meant that staff were able to refer to key information as needed.

Requires Improvement

Is the service effective?

Our findings

People were very complimentary about the food. One person said "The kitchen staff go out of their way for specific requests. They made me a lovely cake for my birthday." Another told us "I like the food here" and a further person was keen to say "They do a lovely spread when it's your birthday - it makes you feel special." One person said "My family come whenever they want and staff will always make sure they get a drink or some food."

Relatives were also happy with the food. One said "My relation is happy to come down for their breakfast but has all their other meals in their room as that's what they want." Another relative told us "My relation lost weight at home but has put weight on since living here." A further relative said "My relation always comments on how good the food is and there is plenty of it." Relatives were also keen to say how much staff encouraged interaction. One relative said "They offer me lunch every time I come - the steak pie is first class."

We were also told how staff encouraged people with poor appetites to eat. One relative said "Staff always make sure my relation eats her food. They are great with them." Another told us "Our relative is not an easy person - but they get them to eat all their meals." People's choices were also catered for with one relative saying "My relation loves the food. Staff always make sure that they get their favourite drink with every meal." We observed staff during the day encourage people to eat and drink and people offered further portions. People were offered a choice of drinks and it was encouraging to see staff show visible choices rather than just verbal ones to aid people's decision making. Where people became distracted or upset staff provided support and encouragement to assist people to eat. One staff member told us "We can order anything we need for the residents" showing that the home tried to meet people's preferences.

We looked at nutrition and hydration records to see if they were being completed properly. The registered manager advised us all care plans were in place for people who needed extra support with nutrition and that food and fluid charts were always filled in. One staff member told us about one person who was on supplement drinks was no longer losing weight. We checked food and fluid charts on the second day of our inspection and found notes said 'drink x 1' or 'all lunch' which did not indicate calorific value or actual quantity. Although some had been completed, not all were recorded in detail meaning that little analysis of could occur of a person's intake, and therefore limited the effectiveness of such information. People were being weighed weekly where they were at risk of weight loss.

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 found the home had applied for DoLS for people whose liberty was being restricted due to the coded key system and /or a motion sensor. However, some of these had been applied for in March and the registered manager had not chased the progress of these since their initial application. Five out of thirty two applications had been authorised and some contained conditions which had been included in the care plans.

We asked staff to explain what mental capacity was. One member of staff said "It's when people can't always make the best decision for themselves. We try and help them have choice and we get as much information from their family as possible regarding their likes and dislikes. We try to let people do as much as possible." They then described one person who liked to help in the kitchen with drying up. Another said "It's not making choices for people; we try and see if they can make their own choices." We could see an effort had been made in writing person centred care plans in relation to capacity. In one record we saw "if [name] is unable to understand what is being said by verbal communication, staff should try hand gestures which will help communication."

We found there were some issues with the completion of mental capacity assessments as some indicated a person had no impairment of brain function despite clear diagnoses of dementia or other mental health issues. Neither was there evidence in all cases the home had sought out clarification on who had authority to make decisions on behalf of people who lacked capacity as consent forms were signed by family members who may or may not have had appropriate authority to do so. We did see evidence of best interest decision meetings taking place and one took place on the second day of our inspection to consider covert medication for one person.

One person told us "The staff know what they are doing - they care for me so well." One relative said "It is clear that the staff are very helpful; very knowledgeable and highly trained". One staff member told us they had completed an in-depth induction which was spent receiving training in all key areas and was followed by shadowing colleagues for a few weeks. We looked at staff supervision and training records. We found staff training was up to date in most instances. One newer member of staff had received all mandatory training in dementia awareness, safeguarding, medication, equality and diversity, person centred planning, communication, end of life care, pressure care, moving and handling, food hygiene and mental capacity awareness. Efforts had been made to consider reflective practice in supervision sessions which meant that staff considered how they were performing in the role and where further training or guidance may be needed. One member of staff told us "I have supervision every three months. Information is shared and we are given the opportunity to feedback any comments or concerns."

Looking around the home we found pockets of untidiness such as beds not made properly and sheets just hanging over divans. In one person's room they were sitting in an armchair with the bedspread screwed up behind their head which meant their posture was distorted. A member of staff came in and we asked why it was there and they took it away. The person's bed was stripped down to the mattress. There were malodours in parts of the home, particularly on the upstairs dementia unit and air fresheners were present which could pose a risk to those with breathing difficulties.

Staff were able to tell us who needed pressure care, why this was necessary and how they managed this. We checked pressure relief charts which should have indicated what and when pressure care was given. In two people's records we saw they had been completed but not at the actual time as recordings were regular two hourly intervals and neither had any recordings since 10am despite it being 1.15pm when we checked. In a different record it was recorded pressure care had been given at 2pm despite it being only 1.15pm. There

was a detailed pressure care policy which stated repositioning frequencies were agreed after an assessment and that people could only be in chairs for a maximum of two hours if at risk. Each person was to have a specific risk reduction plan detailing correct moving and handling procedures, food and fluid charts and repositioning plans in line with pressure relieving equipment. We did not see evidence of person specific repositioning plans in every record that identified this need. This meant that people remained at risk of not receiving appropriate pressure care.

People told us they were supported with accessing a GP or other health professionals as needed. One person said "They make sure I see the dentist and optician whenever I need to" and a relative said "Whenever my relative is off colour, they check it out with the doctor straight away." Communication with other professionals was also noted as positive. One relative said "It gives me great reassurance that the staff team communicate with all health professionals on their behalf" referring to their relative. The visiting nurse said they were happy with the care the person they were attending to was receiving. They said "Staff take advice and the person's legs are healing well." We found evidence in people's care records of regular visits by health and social care professionals indicating that the home was seeking external guidance where necessary.

Good

Is the service caring?

Our findings

We asked people how they were treated by staff in the home. One person told us 'We can always have a good laugh with the staff - I love them" and another said "The staff keep a really close eye on me. It's lovely here". A further person said "They are a lovely set of lasses. They look after me really well. I am not the easiest person sometimes, I can be really awkward but the girls don't seem to mind here."

Relatives were equally complimentary. One relative told us "The staff go above and beyond what is needed" and another said "The staff are first class - nothing is too much trouble." A further relative said "The staff are really lovely - I love some them - honest. We share the care of my relative."

Visiting professionals were also keen to sing the staff's praises. One said "Staff are always helpful with us. They encourage people to be independent" and another told us that there was "Excellent staff interaction. They show genuine compassion and care to all including visitors".

We observed some very positive caring relationships between staff and people in the home. Staff were kind and friendly with people, offering some people a newspaper to read, or chatting to them about their visitors. There was also interaction between people about the afternoon's entertainment on the first day of our inspection as the local school children were visiting to perform some songs. Just after breakfast we heard one person ask a member of staff if they had time to make them another cup of tea to which the staff member replied "Of course, I have. I've got plenty of time." During lunchtime staff also chatted with people, sitting down with them at the table to encourage people to eat and engage in conversation.

People were supported with their hearing aids and glasses to ensure they had optimum communication. One person told us "I need my hearing aid checking regularly and the staff have put new batteries in today." We saw a staff member ask a person if they could clean their glasses "as I hate mine being dirty" and this was followed by asking the person if they would like a cup of tea.

Just after this one person became quite distressed as we were in the lounge and they were unable to remember who we were so a staff member gently moved them out of the lounge, holding their hand and speaking to them in a reassuring tone throughout reminding them that we just visiting. Later, another person became agitated as they could not find their glasses so a staff member helped them to look for them. We saw one person enter the lounge without their watch and became anxious but a staff member immediately went to find the watch for the person. These observations showed staff were paying attention to the small details as much as the key tasks for people.

In the lounge one person was heard to comment they were cold and so a staff member offered to get them a cardigan which was duly obtained. Another person was trying to see the TV but was not in the best position so a staff member supported them to a different seat and asked them if this was better for them. Staff always spoke with people directly and listened to their responses.

There were few episodes of agitation in the home but when people did become distressed staff intervened

quickly and appropriately to distract and divert people's attention, thus diffusing situations. In one instance we saw one person sit in what another person perceived to be their seat and the staff member intervened saying "Come on [name], let's go for a walk." This proved effective enough to reduce the tension and provide the person with some individual attention. Another person kept trying to move from the dining table without their walking aid and the staff member showed infinite patience in encouraging them to sit down initially and then once they had got their frame, to move slowly and safely always holding their frame.

We saw evidence people's written consent had been sought, where they had capacity to do so, prior to care intervention where appropriate. In one record it was recorded the person needed to use the hoist and it was recorded "I am happy to be assisted in this way as staff have explained this is the safest way to transfer without any risk of harm." Relatives told us they were involved in contributing to care plans for people. One relative said "We have been fully involved in writing mother's care profile" and another told us "We see my relative's notes all the time. They share everything with us." A further relative said "My relative gets up and goes to bed just when they want" which showed the home were meeting people's needs as they preferred them to be met.

"The staff always knock on my door and give a shout before they come in" one person told us and we observed this throughout our time in the home. We saw one carer knock on the door and call out ensuring the person responded before entering the room. Just after breakfast one person had left the communal lounge with food on their chin but a member of staff gently guided them to one side and said "Let me get you a tissue to clean your face as you've a bit of breakfast on there." This was done sensitively and discreetly.

Requires Improvement

Is the service responsive?

Our findings

People told us they had a range of activities to participate in. One person said "I love the dancing and the music, the Elvis night is great. I can't wait for him to come again." Another person told us "We play all sorts of games - bingo and dominoes are best." A further person said they had recently been on two trips to local museums. Other people told us they had been out on a local miniature railway and enjoyed afternoon tea, and also went on shopping trips. One person told us "I am looking forward to seeing Strictly Come Dancing at the theatre in the autumn."

Relatives were also keen to say how much people benefited from such events. One relation said "My relative is really encouraged to join in the leisure activities. I can't believe it; we never thought they would". We observed people's enjoyment when the children from the local primary school came to sing as they joined in with the singing and hand movements. One person told us "I have loved all those children's faces singing. I wish they could come every day." We noted people tended to congregate with their relatives in the coffee lounge downstairs and enjoy some social time together during the afternoon.

In other areas of the home we observed people sat in another area quietly playing dominoes. One person told us "I stay in my room most of the time but I do walk around the home and go outside whenever I want to. I like to work in the garden". In the dementia units we found staff having one to one time with people later in the day. We saw staff talking to people about local history books and this attracted others into the conversation. There was a good deal of reminiscence and people became engaged with each other and the staff. We also saw staff playing games with people such as Connect 4 or cards, painting people's nails and undertaking craft activities such as making cards.

During the morning when staff were more pressured, we saw the TV on in one of the lounges while people were supported to have breakfast. One person was asked if they would like the TV turning up or some music on and when they chose the latter, this was done but the TV was left on. The regional manager entered this lounge and asked the staff member what activities were planned and they advised them "I haven't got that far yet but there might be hand massages later." As it was a hot day the regional manager suggested people may wish to go outside. However we only saw people that were independent do this during the day as there were not enough staff to support others who remained inside. One relative did tell us "The staff are great with my relation but we have to watch for the small care needs not being met" as they indicated staff were so busy.

We looked at people's care records and found them person-centred. In one file we saw appropriate care planning around supporting a person who had an infection and detailed notes about their condition to assist staff's awareness of how to best care for them. Records indicated where the person had dressings and contained evidence of regular district nurse input to manage the change of dressings.

Records contained all necessary information regarding a person's identity such as a photo, date of birth and allergies. We saw information about a person's family had been completed by family members where appropriate to assist staff in understanding the person more. Each person's need had its own assessment

followed by a care plan indicating how this need was to be met. Language was much more focused on the person than we had observed at the previous inspection. In one record we noted "Often needs care staff to remind [name] of choices, orientate to time and place, and reassure [name] of why they are living here" as they were living with a diagnosis of Alzheimer's disease. In another it said "I don't mind using the hoist – it makes me feel safer transferring. The carers explain what they are going to do so that I can be reassured." Each of the care plans was evaluated monthly and again we found evidence that this reflected actual events such as being unwell and what action had been taken as a result.

Daily communication records were current but mostly task-focused. Comments included "independent with toiletting' and 'good diet and plenty of fluids'. People's specific activities were noted such "[name] has been in their room dressing and undressing, and sorting clothes until 1.35pm". This showed that staff were monitoring people in their own rooms as much as those in the lounge, and respected people's right to privacy.

We observed one person in their room who looked neglected due to being unshaven and having long hair, and poor skin quality. Their room was also neglected as the divan was discoloured and their tray table was dirty. Their room was 28 degrees centigrade which was very hot and staff were not able to pay much attention to them as they were busy supporting other people. We checked their care plan and saw they had a particular skin condition. They had records of regular multi-disciplinary visits from the GP and district nurses but no evidence of a visit from the chiropodist. It was also noted that they sometimes refused assistance with personal care but it wasn't always clear how staff responded to this aside of giving reassurance. We could not see multiple entries of staff retrying to engage with the person.

Each unit had a floor management file containing key records including short term care plans if someone had an infection for example, post accident observations, food and fluid charts and pressure care charts.

People and their relatives knew how to complain and they told us they would inform the staff if they were unhappy with their care. We saw the complaints procedure on display. People we spoke with said they had raised issues which had been dealt with and they had been happy with the outcomes. One person said "I would not hesitate to take action if I have even a tiny concern" and a relative told us 'My relation is happy here but I would go to the office if I had any concerns. We have in the past and things get dealt with." People and relatives were equally happy to approach staff or the registered manager. One relative said "I have no complaints - it is exemplary how things are run here."

We found the home had two complaints logged for this year but both had been sent straight to head office. The regional manager advised us they reviewed any complaints at their regular visits which assessed care, occupancy and staff. They told us they fed in to the home's service improvement plan.

Requires Improvement

Is the service well-led?

Our findings

We asked people how involved they felt in the running of the home. One person said "I have been invited to meetings - but who needs them? I am happy with everything" and another told us "I have filled in a questionnaire but I'm not sure what happened though." A further person living in the home said "We only have to ask for something and we get it." We saw the home had conducted a resident survey in May 2016 but had only received four replies. It was not evident what action had been taken to comments made by people such as them not knowing who their keyworker was. We spoke with the regional manager about this and they advised us this work was an ongoing action.

Relatives were again complimentary. One relative said "We have every faith that [name] is in the right place. I can rest at night now, knowing they are in good hands." Another told us "The staff contact us about every little thing regarding [name]. It just gives you so much confidence in the service here." A further relative said "I love the atmosphere and philosophy of good communication."

There had not been a relatives' meeting since April 2016. Relatives that could not attend that meeting stated they would attend other meetings if they were held. However, they had not had minutes or messages of the outcome of the meeting that took place.

One staff member was keen to tell us "I am new here. I have worked in other homes but this is the best by far." Another wanted to stress the support they received "I would feel able to raise any issues with the manager and it's nice to get feedback on my performance. We are asked our opinion at staff meetings and can put ideas forward. We had a meeting recently regarding activities as we realised they were always the same ones." The visiting health professional was also positive saying "I am definitely bringing my relation in here when the time comes. I've told them."

Staff told us they felt the home was run well. One staff member said "We are trained to do all tasks so we can cover anywhere. I'm well supported in my role and it is better now there is a floating member of staff." A different staff member told us "Managers will help out if staff cover is needed. I generally work on the same unit as this is better for the residents, and relatives have told me they prefer this continuity of care." They continued "I know what residents like and dislike, and am more aware of their needs than before."

Relatives had favourable comments regarding the registered manager. One relative said "I know without a doubt that the manager would take any of my concerns seriously" and another told us "[name] hugs the staff. I know that means they loves them." We observed the registered manager around the home and it was evident they were well liked and they knew people well. One person living in the home said "The manager is always asking us if we want anything to change" and another told us "The manager is lovely. They are so helpful."

We found evidence of monthly staff meetings up until April 2016 and then we were advised by the registered manager that no one had turned up for the one scheduled for 25 May. They did not offer an explanation as to how they had addressed this. We saw staff were advised of the increase to staffing levels due to people's

dependency levels. The rota was to be ten staff during the day and five at night, and staff were to be allocated units dependent on their skills. Staff were advised to come and talk to the registered manager if they had any concerns.

In a subsequent meeting staff views were sought on the impact of remaining in the same units as they said "staff agreed being in the same unit was working much better as there was a definite consistency with staff getting to know people's needs." Guidance was also given to encourage people to join in with daily tasks such as setting tables and folding napkins although we did not see much of this during our time in the home. One staff member actually said "I like to feel I am making a difference. I get satisfaction from this as I like to be with people. I enjoy doing activities…[name] likes to help me with tasks like setting the table."

We looked at the monthly audit file which included a variety of tools. There was a dependency analysis which assessed people's needs for two staff in regards to moving and handling and sleeping patterns. However, there was no consideration around people's behaviour patterns such as anxiety or memory loss. The medication audit included a stock balance sheet which was not signed to say who had completed it although the registered manager later told us they had. No issues were recorded and yet we had discovered the medication trolley lock was broken, and had been for a period of two weeks.

There were also audits for weight loss, near misses and accidents, pressure sores, mattress conditions completed by the deputy manager, and housekeeping. The pressure sore audit included information to show that people were always referred to the district nurse for any concerns which showed the home was taking appropriate measures to support people. The housekeeping audit had been signed by the registered manager and agreed as everything was clean and well presented and yet we found fridges on the units dirty and containing out of date food. The registered manager said night staff were responsible for cleaning fridges and that the registered manager completed spot checks. However, these were not recorded and the cleaning schedule had been ticked by night staff to say that cleaning had taken place. This meant although there were numerous audits in place these were not always identifying key issues or generating action plans to resolve important issues.

The registered manager advised us they completed walkarounds the home but not every day to make general observations and we found these recorded in a log. There were six entries for the past three months. Positive comments were recorded about interactions between specific staff members and people in the home. However, the information was brief and we found only one action point established as a result. One entry identified an issue with lack of activities but nothing further was recorded showing how this was to be addressed. Care plan audits were equally sparse with information often being incomplete.

The progress of the service improvement plan was reviewed monthly by the regional manager. They considered the accident information, the audits, medicine administration records, occupancy and staffing levels. We saw recorded that a decision had been taken due to the lower levels of occupancy that staff could be sent to other homes owned by the registered provider as only nine staff were needed to manage. However, our observations on this inspection did not support this view. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found that audits had not identified key issues and the suggestion that staff could be moved elsewhere did not reflect the needs of people in the service.

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 17 HSCA RA Regulations 2014 Good governance We found that audits were still not effective in identifying areas of poor practice or issues in the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no person specific risk assessments in place for people who needed assistance of staff and equipment to transfer. Medicines were not stored or administered safely in all cases, and infection control measures were poor.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Although improvements had been made in regards to continuity of provision, we still saw that staff were moving between units frequently and that people told us they had to wait.

The enforcement action we took:

Warning notice