Athena Care (Ormskirk) Limited

Abbey Wood Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on the 21, 24 and 25 July 2017. The first day of the inspection was unannounced which meant the provider was not expecting us on the date of the inspection.

Abbey Wood Lodge Care Home is a purpose built care home on the outskirts of Ormskirk, Lancashire. The service can support a maximum of 60 people with residential care needs. At the time of the inspection there were 52 people living in the home.

The home is designed over three floors. The ground floor supports people with the least support needs and the upper floor supports those with higher support needs. People on the first and second floors are primarily living with varying degrees of dementia.

Each floor has dining and lounge facilities and communal bathrooms, we were told each room (with one exception) had a wet room with ensuite shower and toilet. There is a large kitchen on the ground floor and there are laundry facilities on the upper floor. The first and second floor also had a satalite kitchen.

The home had a registered manager. 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 last inspected the service in April 2015 where eight breaches to the regulations were found. Two of the regulations were found to be breached twice at the 2015 inspection. Since that inspection there has been two managers of the service and a high turnover of staff. In the three months prior to this inspection the senior leadership has expanded and further support had been provided to the home.

We found work had begun to meet the requirements of the regulations but the majority of this was still to embed to have the desired impact on the care provision at the home. We could see work had been done to meet some of the previous breaches but we found there were five continued breaches from the last inspection and we identified five new regulations in breach including one of the registration regulations. We found the home did not have a clear statement of the terms and conditions with respect to the payable fees.

At the last inspection we found the management of medicines regulation in breach. At this inspection we saw some work had been completed in attempt to manage the concerns in medication management but records remained inconsistent. We found prescriptions were not always followed and information to support staff in the management of medicines needed review. We found the home in continued breach of the medicines regulation.

At the last inspection we found the home in breach of the regulation associated with ensuring the risks to

people's health, care and welfare were appropriately assessed. Those assessments should lead to plans of care that identify how those risks are to mitigated, reducing the risk to people living in the home. We continued to find concerns of this nature at this inspection. Where risks were identified to the people including risks of malnutrition, pressure areas and inappropriate behaviour these were not always assessed or managed in line with the regulations. We found the home in continued breach of this regulation.

At the last inspection we found the system of quality audit and assurance was not developed meaning the home had not taken appropriate action to ensure the service provided was monitored and risks were reduced. At this inspection our findings were similar. A high level system had been developed by the new management team but the systems beneath this required further thought. Some had not been completed for some time and many of the policies and procedures in the home were in need of review. We found the home in continued breach of this regulation.

At the last inspection the home were found to be in breach of the regulation associated with consent. At this inspection we saw some work had been done in this area. However we found consent had been provided by some families on behalf of some people in the home that did not have the legal authority to do so. We also saw a number of decisions had been made on behalf of people where their consent was required, this included the use of bedrails. The more generic consents had not been acquired for everyone in the home. We also found a number of consents had been acquired which had not been incorporated into the care planning for people. We found the home in continued breach of this regulation. Since the inspection we have seen evidence the provider has taken steps to address some of these concerns. We will check on this at our next inspection.

At the last inspection the home had not submitted applications for Deprivation of liberty safeguards when people living with dementia were not free to leave the home. At this inspection we found people had not received appropriate assessment to ascertain if they could consent to their bedroom door being locked. When people lack capacity and are unable to consent to restrictive practice a decision specific assessment should be completed. If that assessment determines a lack of capacity for the decision then if appropriate a best interest decision should be made. Any decision made, should be the least restrictive option available. There was not any evidence this process had been followed when locking bedroom doors. We also found safeguarding alerts had not always been made to the local authority as required. This meant the home was now in breach of the regulation associated with keeping people safe from abuse.

At this inspection we found there was not enough staff to meet the needs of people in the home. Our primary concern was those people living on the top floor and particularly through the night. We shared our immediate concerns with the provider who took immediate action to ensure there were never less than three staff on duty on this floor through the night. We discussed the staffing at the home and asked why staff vacancies were not being filled by agency staff. We were told the home preferred to use their own staff who knew the residents. We discussed the need to ensure that all the staff required to meet people's needs on each shift needed to be filled by staff even if this was from agency. We also found, there was not a consistent model used by the home, to identify the staffing required to meet people's needs. We found staffing in the home needed further consideration staff and people in the home and their relatives thought more staff was required. We found the home in breach of this regulation.

We reviewed the records the home held about complaints. We saw a policy was available which had been due for review some 18 months prior to the inspection. We looked at the available information within the complaints file to identify how the home managed complaints. We found the home was not following their own guidance and procedures for managing, recording and responding to complaints. We found the home in breach of this regulation.

At this inspection we found concerns around the safety of people in the event of a major incident including a lack of monitoring of safety equipment to reduce the risk of major incidents. We found records used to support staff in the event of a major incident were confusing and staff we spoke with was unsure of the correct procedure to follow. We found the home in breach of this regulation.

We found support was not effectively delivered to reduce the risks to people of malnutrition and dehydration. Records used to support those at risk were poorly completed and were not used effectively to reduce associated risks. Actions agreed to mitigate risks were not routinely followed and risk assessments and care plans not routinely updated to reflect the current needs of people. We found the home in breach of this regulation.

During this inspection we observed many positive interactions between staff and people in the home and it was clear staff had the best of intentions. However due to lack of knowledge some staff did not behave in a way that promoted the dignity, autonomy and independence of people in the home. This included delivering support interventions without appropriate agreement, not providing choices in a way people understood and not mitigating potential risks to support people to remain as independent as possible. We found the home in breach of this regulation.

The ratings from the last inspection were displayed in the home. The ratings were not on the website prior to this inspection but have been displayed on the website by the time of the final report. The provider will need to update the website with the new rating within 20 days of the publication of this report. The commission's ratings of a service are required to be made available by the provider to both the people using the home and those that are viewing the home as a prospective placement for their loved ones. We have recommended the provider ensures the website is updated when required.

During this inspection we reviewed the previous breaches to the regulations. The action plan sent by the provider following the last inspection could not be found. The action plan had not been sent to the central mailbox for the inspector to retrieve as part of the inspection planning. This meant we could not review the changes the provider thought they needed to make to meet the requirements of the regulations prior to the inspection.

However during this inspection we noted three of the previous breaches had now been met. We found the detail of one of the previous noted breaches now had become part of a bigger concern, specifically relating to the fire equipment testing and this information had formed part of a breach for a different regulation.

We previously found the design, adaptation and layout of the building was concerning enough to constitute a breach. At this inspection we still had some concerns in this area but could see some work had been done including better identification of specific areas namely bedrooms and communal areas. We could see memory boxes had now been filled to enable people to better find their own bedroom. We have made a recommendation to the provider in how to improve this to ensure the service improves the strength in which it meets the requirements of the regulation. If the home is to continue to support those people living with more advanced forms of dementia and with the acknowledgment the needs of the current people living in the home will increase, further work will need to be done.

At the previous inspection we found care plans were not sufficient to meet the needs of people in the home. Again we did still have concerns in this area, but it was clear newly developed plans of care and the care plans and risk assessments for those most at risk, had been updated and were comprehensive in addressing concerns and providing staff with information to support people. However, it was clear that older records still required more work. We have recommended the provider reviews and audits the content of all care

plans and ensures they are relevant to meet people's needs.

At the previous inspection we were concerned that staff were being recruited that did not have the skills and competence to meet people's needs. We found the recruitment process had much improved. However, we have made a recommendation, to ensure all staff files are reviewed and those that did not complete a comprehensive induction, are given the opportunity to complete or finish one. We also recommended, that when references identified potential concerns, that records were held around discussions to mitigate any foreseeable risk.

We made a further seven recommendations to support the home to drive forward improvement. These included recommendations around the management and audit of records including those used to monitor accidents and medication. We recommended current information held at the home was reviewed to ensure it was complete around the requirements of the Mental Capacity Act, referrals made to external support networks and available and suitably deployed staffing. We also recommended the home ensured it had enough available equipment to meet the needs of people living in the home

The overall rating for this service is 'Requires improvement'. 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.

There were not enough suitably trained staff to meet the needs of people living in the home. The top floor was a particular concern and needs further review even after an immediate increase to staff numbers

The Home's plans in the event of an emergency evacuation were not consistent; staff did not have a clear message on how to safely support people in the event of an emergency.

Risk assessments for both the safety of the environment and the safety of people living in the home were not adequate.

The safe management of people's medicines required more thought. Record keeping was inconsistent and plans to support people with their medicines were incomplete. People were not administered medicines safely and in line with prescriptions and protocols.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems and records used to support people with the risks associated with malnutrition and dehydration, were not effective.

We found further work was required to ensure people had given suitable and required consent. These included people consented to their own care and treatment when they had the capacity to do so and when not, other suitable consent was acquired under the guidance of the Mental Capacity Act 2005

The service had begun to develop procedures of assessment and decision making under the Mental Capacity Act to support those people in their best interest.

Training and support provided to staff had improved over the previous months and staff were beginning to feel better supported. The newly appointed trainer was a positive asset for

the team's development.

Is the service caring?

Requires Improvement

The service was not always caring.

Families told us they were involved with the development of their loved ones care plans and people living in the home felt they could influence their care.

We observed that staff were respectful and the staff had positive relationships with the people living in the home. People we could speak to were complimentary about the staff that supported them.

We found staff did not always understand the principles of providing choice and supporting independence for those people living with dementia. We also found some interventions were task focused and were not always delivered in agreement of the person being supported.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The home had developed activities which were held in the home and external outings were planned. The provider had developed a network of activities with other similar providers. There was a shortage of meaningful activity and occupation for those living with dementia and this required further thought

We found people's care records were difficult to follow and information was not all held with the person's file. The quality of these records was inconsistent and we have made a recommendation for this information to be reviewed to ensure it holds the current picture for everyone living in the home.

The home's complaints policy was past its review date. Complaints had not been handled in line with the policy or available procedure

Is the service well-led?

Requires Improvement

The service was not always well led

The new senior leadership team had introduced quality visits and a home improvement plan. This enabled a high level review of the service. However, the monthly and quarterly monitoring that should underpin this was not fully developed and had been

inconsistently completed.

The home was shifting its culture and staff and people in the home were more confident there would be improvements in service delivery.

Risk assessments were basic and needed to more clearly identify the risk and how it would be managed. Systems of quality monitoring were required to monitor the management of the identified risks.

Policy and procedures were out of date and had not been updated for some time. New policies and procedures were yet to be embedded in the home.

Abbey Wood Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 21, 24 and 25 July 2017 and the first day was unannounced.

There were four adult social care inspectors, only one of which attended on all three days. We also had a dementia nurse as part of the inspection team and two experts by experiences. 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 case the experts by experience had experience of caring for someone living with dementia.

Prior to the inspection we reviewed all the information the commission held for the home. This included notifications to the commission from the provider and information from external professionals including the Local Authority safeguarding team and contract monitoring team.

During the inspection we spoke with 17 staff including members of the senior leadership team, the registered manager, deputies, senior carers and carers. We also spoke with members of the catering, domestic and maintenance team.

We looked at 15 care files of people living in the home and reviewed the electronic care planning system. We looked in details at six of these files tracking the support people required to meet their needs. We also looked at nine staff files to ensure staff were safely recruited to their role.

We looked at management information including accident and incident records, audits of service provision and complaints. We looked at the records used to safely administer medicines and the maintenance and

general safety information available for the home.

We observed how staff and people in the home interacted and completed observational exercises to ascertain how those who could not communicate with us received quality care. We spoke with 12 people who lived in the home and four relatives and visitors.

We looked around the building in all communal areas, the office spaces and people's bedrooms.

Inadequate

Is the service safe?

Our findings

It was difficult to speak to people on the top two floors of the home due to their dementia. People we spoke with on the ground floor told us they felt safe. One person told us, "Mostly, unless my door is closed unnecessarily as I like it open." Another person told us how staff reduced the risk of them falling. We were told they had fallen at home and were anxious they would fall again, they told us, "Staff walk beside me when I'm walking and when I stand up they put a chair behind me to prevent me falling."

The home had not developed a dependency tool to support them in identifying the required numbers and skills of staff to meet the needs of people in the home. We were told the home had access to a dependency tool but they were not using it. We observed a number of occasions where the allocation of staff meant staff were left alone. Staff told us in these instances and when other staff were not available they moved people independently when they knew they had been assessed as needing two members of staff.

During the night there were two staff on each floor of the home. It was clear the needs of the 12 people on the ground floor were much less than the 20 people living on the top floor yet the staffing levels were the same across each floor. We spoke with the management about this and an additional night staff member was immediately put in place on the top floor. We were sent rotas for the coming four weeks identifying there were always three staff on the top floor through the night. The top floor was also supported by the night manager who oversaw the whole building. We recommended the provider urgently review staffing levels across the home and ensure they meet the needs of the people living in the home. It was crucial that night staff were able to take suitable breaks without leaving one member of staff supporting a number of vulnerable people. We also recommended that staffing levels to the top floor was reviewed in four weeks to ensure that three staff was enough to support the very vulnerable people on this floor.

We were told by the management team that internal staff supported covering the rotas and were working additional hours to cover current vacancies. We spoke with staff about this and were told they had holiday declined as there were not enough staff to cover the existing rota. Staff told us they were tired but wanted the service to succeed so they carried on working additional hours.

The home had current vacancies which they were recruiting to. The manager assured us moving forward they would continue to ask current staff to cover the rota and where gaps remained agency staff would be used as required. We were also told a twilight shift from 6 to 11pm was due to be introduced.

People we spoke with who lived in the home, and visitors told us the number of staff on each shift had not increased since the home first opened despite the numbers of people in the home having increased significantly. Staff and people in the home told us staff would get called to another floor during shifts to cover shortages leaving the floor they should be working on short staffed.

When there are not enough suitably qualified staff to cover the rota, to meet the needs of people in the home in a timely and safe way it is a breach of regulation 18 (1) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We reviewed the available information on safeguarding incidents. We found that a number of incidents had been recorded that should have been referred to the safeguarding team. This included incidents between staff and people in the home, between people living in the home and unwitnessed and unexplained injuries. We looked at the recent training undertaken and saw that approximately 75% of staff had recently completed e-learning in this area.

The manager acknowledged that more work was required in this area and the deputy manager and three staff were due to join the safeguarding champions group. This is a county wide group chaired by the Local Authority Safeguarding Board. The forum is used to share best practice and develop appropriate support networks amongst service providers across the area.

The safeguarding contact numbers were available in the home for staff to use if required. Staff had a good understanding of safeguarding and were confident to raise concerns if they saw inappropriate practice.

We found a number of bedroom doors were locked. We looked to see if consent had been acquired for this and found it had not. There were no assessments as to why the rooms were locked and no assessment to determine if the occupant of the room had the capacity to agree for their room to be locked. There were no best interest decisions to ensure locking bedroom doors was the least restrictive option.

At the last inspection we had found appropriate deprivation of liberty safeguards had not been applied for. At the last inspection we found people had not been appropriately assessed who were unable to leave the premises. At this Inspection we found people had not been appropriately assessed who were unable to freely enter their bedrooms.

When potential alerts are not raised with the Local Authority safeguarding team, homes do not receive the support they need to ensure people are protected from abuse. We found appropriate assessments had not been completed when people were restricted this constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the specific individual risk assessments to support people with their needs. We found these were not person centred and were predominantly tick lists. We found that action and comprehensive care plans were not always developed when risks were identified. This included risks associated with pressure damage, malnutrition, falls and self-neglect.

We saw one person's bed rails risk assessment identified they might attempt to climb over their bedrail. The assessment instructed the rail should still be used as there was not an alternative. The use of bed wedges had not been considered and there was no clear consent or agreement to the use of the bedrail. The provider had rectified the situation upon receipt of the draft report. An assessment could not be found to determine if the person had capacity to agree to risks associated with the bedrail or if they understood the risks of attempting to climb over.

At the last inspection we found the provider in breach of this regulation. We found the same concerns at this inspection.

We found the provider continued to not appropriately assess and manage risks to people living in the home. Suitable plans were not developed to support people against those risks therefore this was a continued breach of regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that most rooms had a Personal Emergency Evacuation Plan (PEEP) outside the door. This would be

used to support the person in the event of an emergency. We also reviewed the PEEPs held in people's individual files. We found a number of PEEPs had not been updated for over a year. We found all of the PEEPs in people's files identified action for staff to escort people out of the building. We found the home had colour coded the level of need of people from red, as requiring maximum assistance, to green, which meant they were independent and needed minimal assistance. We found the colour of the code on the PEEP in people's files did not always correlate with the colour code of the PEEP outside their room.

We reviewed the information available to staff in the fire file. There were three different procedures with no clear direction as to which should be followed and when. One identified staff leaving the building immediately. One identified staff ensuring people were escorted to the furthest dining room from a fire and another identified moving people to stairwells. The two staff we asked about emergency evacuation were unclear of the procedure. We had concerns as to how many staff would be clear.

We looked at the records for the testing of the equipment to prevent and reduce the risks of fire. The fire alarm bell test had not been completed since February 2017. The required weekly or monthly checks on fire doors, extinguishers and lighting had not been completed since May 2017. On the day of the inspection we saw a new maintenance person had begun in the role. Management assured us that the testing of the equipment would fall to them and the absence of a maintenance person was why the equipment had not been tested.

A fire risk assessment had been completed in June 2016 and had identified a number of actions. This included the ground floor electric cupboard being used as storage of combustible items. We saw on the first day of the inspection that this was still the case. We were assured on the last day of the inspection that this had been emptied.

We also found the contingency plan did not correlate with the evacuation plans and details of a named provider who was to support the home in the event of an emergency was no longer in use.

We found the lack of consistent information within the PEEPS and the conflicting information within the evacuation and contingency plan left a risk of an unsafe and unorganised evacuation. We found the lack of the required testing of equipment and the lack of implementation of actions identified from a fire risk assessment 12 months prior to the inspection left a potential risk of ineffective equipment. The lack of consistent testing of safety equipment and lack of consistent planning for emergency situations is a breach regulation 12 (2) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the medicines administration round on two floors of the building. We found staff were respectful and patient when administering medicines. People had options to refuse medicines and those that required more support with their medication received it. We saw staff supported people with administering their own medication, namely inhalers and found support was appropriate to the person's needs.

We found medicine trolleys were either secured in a clinic room or chained to a wall. We advised the senior carer administering medicines not to leave medicine on the trolley unattended and had to ask a staff member to remove a pill from the side in one person's bedroom. Leaving medicines unattended poses a potential risk of unsafe administration.

We found fridge temperatures were not routinely taken and one fridge had been incorrectly recorded for some time. The back of the fridge was iced up and clearly out of temperature range. We shared this information with the manager who immediately contacted the pharmacy who attended and repaired the

fridge. We also found a urine sample in the medicines fridge which was not named or dated. We recommend if the provider is to take samples on behalf of doctors they develop a more robust system for the safe and clinical storage of the sample. The sample was removed later that same day.

We found the records used to record the administration of medicines had details of the relevant information including a photograph of the individual and if there were any known allergies. We noted from audits that gaps in MARs had been a problem. We saw a memo requesting staff who had missed signing the records to ensure they went back to sign them. This was not good practice and the manager was informed the postdating of MARs was not an acceptable practice.

There continued to be gaps in recording on the day of the inspection. There were no records to identify the reason why. We also noted PRN as required medicines were given routinely on the top floor of the home. Many people had paracetamol as a PRN medicine. The prescription for all the paracetamol prescriptions contained the same commonly known information. No more than eight paracetamol to be given in any 24 hour period and doses to be four hours apart. We looked at seven MARs charts for the administration of paracetamol and found they had not been given with a minimum of four hours in between each dose. We also noted that paracetamol PRN protocols were not routinely followed and protocols for a controlled drug PRN was not in place as required. We raised this with the management in the home and found they immediately contacted staff responsible for giving medication to remind them of the correct procedure for administering paracetamol.

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We reviewed the available procedures staff had to guide them in administering medicines and we saw a policy was available in the medication room and in the front of the MARs file but this policy was due for review. We saw a number of handwritten audits had been completed and where concerns had been noted clear instruction had not been given. The management of medication and the management of medication errors had not been consistent for some time. The new deputy manager was aware of this and was developing systems to drive improvements.

We saw two people received their medication covertly. This is when medicines are given in another substance or disguised in some way to better support people to take their needed medicine. There was not any assessment of the capacity of these people to ascertain if they could consent to this. We did also see two others where assessments had been completed. We saw notes of best interest decisions in medical notes which were not formally signed off. We also saw an undated note of a best interest decision with little information on it to support the decision. The other had a note from the person's daughter to say it was ok to give medicines covertly. We checked to see if the daughter had the authority to do this and found they had power of attorney for finance and property only and therefore were unable to make this decision.

We found inconsistencies across the home in how medicines were handled and managed this included the dating of boxes and creams when they were opened and the administration of topical creams.

We found the home failed to administer and manage medicines in line with good practice guidelines and had not reviewed their own policies to ensure they contained the most up to date and relevant information to support staff. We found prescriptions were not correctly followed and staff needed more support with administering medicines to people who lacked capacity. We found the home in continued breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management at the home had been proactive in implementing a daily audit. This reinforced the need for staff to correctly complete the MARs whilst administering medication. However, there continued to be gaps in the MARs which were not explained.

It was clear the reporting of accidents and incidents has evolved over the previous 12 months prior to the inspection. However, the different tools used to monitor and record accidents, incidents and falls separately were confusing to digest and there were some inconsistencies in the records. It was only clear in some records what actions has been taken and what preventative action would be taken moving forward to reduce the identified risks. A falls calendar was introduced in June 2017 which gave more specific individual detail as to whom and when people fell. This allowed for a better overview of when people had fallen more than once and needed additional specialist support. We recommend records are consolidated to reduce the risk of inconsistencies and allow the management team to better monitor themes and trends and develop strategies to reduce both environmental and individual risks.

We found the professional testing of equipment was mostly completed including electrical and gas installations, hoists and lifting equipment. We found the testing of the home's profile beds had yet to begin. We were sent details of verbal contracts and information to show the testing was due to begin.

We saw a number of monitoring records were to be introduced the week of the inspection to ensure domestic staff completed the tasks expected of them. This included the cleaning of both communal and private bedrooms. Records identified that five bedrooms were deep cleaned each day and that staff signed to say they had completed a number of other tasks.

New monitoring records also included the requirement of domestics to check health and safety aspects of rooms including window restrictors, that the fire door fitted into its frame and that shower chairs were in good condition. There was also an additional sheet for works to be passed to the handyman for completion.

Domestic staff told us they had everything they needed to complete the job and had enough staff resource to complete what was asked of them.

We found the cleaning of the medication/clinic rooms was not included in the monitoring information and the housekeeper ensured this would be added.

We saw staff had available personal protective equipment at point of need including in the sluice rooms and bathrooms. Staff also carried hand held antibacterial gel to ensure their hands were clean. We saw that the home did not have clinical waste reciprocals in areas other than the sluice rooms. This meant staff were walking with clinical waste down communal corridors or put in bags on the side of domestic trolleys for disposal in the sluice rooms.

An IPC audit had not been completed since December 2016 and we found the flooring in the sluice rooms and clinical rooms were sticky under foot.

We found the new monitoring information would identify risks and gaps in current procedures and we were assured steps would be taken to address any shortfalls. We recommend an infection prevention and control audit is completed regularly moving forward to ensure these areas are addressed.

We reviewed the personnel files of nine staff. It was clear that those staff employed earlier had not followed as a robust recruitment process as those recruited later. We recommend an audit is undertaken of all staff files and when those staff recruited earlier are found not to have received a complete induction, that this is completed. We found appropriate checks were completed prior to staff employment to ensure they were suitable for the role. However we noted a reference that identified concerns in one person's practice. We spoke with the manager about this, who told us this had been explored during interview. We recommend

risk assessments are completed when concerns of this nature are shared to ensure the home are safeguarded from potential risks moving forward. We saw interview records were completed and staff received contracts of employment which were signed.

Requires Improvement

Is the service effective?

Our findings

People told us they thought the staff were equipped to meet most of the needs of people in the home but they thought the top floor did pose the most difficulties. The top floor supported people with more complex needs. One visitor told us, ""The staff know [relative] well and know what she needs."

We saw a number of circumstances where staff needed more support, guidance and training on how to deal with situations. This included the meal time routine and supporting people with choices. It also included staff acquiring the confidence to intervene in situations that could become volatile in a safe and structured way. Staff told us they had not received specific training in supporting people living with advanced dementia. But we did see from the training matrix that 75% of staff had attended specific training in managing potentially aggressive situations. The newly appointed nominated individual had taken on the role of delivering some of the training. They had also begun to undertake pre and post course evaluations to ensure the learning was consolidated and acknowledged there was more work to be done in this area. We observed incidents between people in the home that staff either didn't observe or choose not to intervene. This included one person putting their hands in another person's food and the person becoming upset.

Staff we spoke with told us they had completed mandatory training in the last 12 months and we could see from the training matrix and the manager's file that this was mostly up to date. The new nominated individual had taken up a training role as part of their remit and had shared additional learning resources including information on conditions such as Parkinson's and dementia. They were to begin using the home's policies as training resources to ensure staff were aware of and following specific policies in the day to day management of the home. The nominated individual was aware staff needed more support in dealing with challenging behaviour and had started to implement programmes to address this.

Senior day staff told us they felt supported and all staff were hoping things would improve with the introduction of the new management team. Staff told us they received formal supervision approximately every four months and senior staff told the door to the manager's office was open if they needed support at other times. When people first started at the home they received an induction and spent three days shadowing more experienced staff. Some older staff had not received as comprehensive induction and we recommended within the safe key question for the home to review this and provide additional support if required. Staff were supported by the provider to gain care specific qualifications relevant for their role. Staff told us the delivery of training had recently improved greatly.

We could see from records that team meetings were beginning to become more routine and had taken place every three months since December 2016.

We observed how staff gained consent prior to the delivery of care. When serving cups of tea we saw staff ask people if they wanted a cup before it was provided. However we also saw more task focused interventions where consent was not acquired, this included one person being told they were going to the dining room for lunch. On another occasion a staff member put a stand aid sling behind one person and told them, "We are taking you to the toilet." The person said, "I might not want to go." The staff member

replied by saying, "Its ok we can try."

We saw the home had a number of proformas for consent. These included consent for the service to administer people's medication, consent to have people's photograph taken and in agreement to people's care and treatment. We found these were predominantly completed once and were mostly signed by family members. We saw records that stated family members had power of attorney but there was no evidence to show which type. Power Of Attorney (POA) can be awarded to give consent on someone's behalf for their financial management or for the management of people's care and welfare. We asked the management to produce evidence of someone's POA for care and welfare and noted it was only for their financial management and support. This meant this person was not authorised to give consent for decisions involving the person's care and welfare. Decisions around a person's health will be made in consultation with the family but the lead clinician would authorise the decision and be accountable for it. Where people who lack capacity to make decisions do not have a legally appointed representative an advocate should be appointed to advise on social and welfare decisions.

We also saw a number of decisions had been made on behalf of people where their consent was required, this included the use of bedrails. We also found more generic consents that had not been acquired for everyone in the home. We noted a number of consents that had been acquired which had not been incorporated into the care planning for people. This was found to be a breach at the last inspection and the risk of care and support being provided without the required consent remained a concern. This is a continued breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 saw the home had completed some capacity assessments for specific decisions to determine if people had the capacity to make them. However this practice was not consistent across the home. Assessments completed included to ascertain if people had the capacity to choose to stay at the home and be supported by staff and for support with their medicines. We saw that since the last inspection a number of DoLS applications had been made to the Local Authority. We saw the home contacted the DoLS team bi monthly to ascertain the progress of the applications submitted. We also saw some best interest meetings had been recorded in people's notes for the use of covert medication.

However we also noted that a number of assessments had been completed which identified a lack of capacity in specific areas and the home had not always followed these through to best interest or DoLs applications. We also found assessments and decisions were not consistent in both how they were completed and when they were completed. We discussed this with the new management team within the home and were assured that this piece of work would be addressed as a priority. This would ensure that

people in the home were protected under the MCA. We recommend the provider completes a review of the available information the home holds around people's capacity and ensures assessments, and where required appropriate decisions are recorded in line with the MCA.

We spoke with the kitchen staff and chef and were told they were in the middle of a consultation exercise with people in the home to develop set menus. Kitchen staff were aware of the needs of the people in the home including their type and consistency of diet. We were told there were eight diabetics in the home. Staff also knew of any food allergies people had.

A choice of food was given to staff for the next day's menu. Staff then asked people what they wanted from the available choices. If on the day people changed their mind we were told the chef catered for them by providing basic home cooked food including omelettes, beans on toast or sandwiches. However, we did not see this to be the case on the day of the inspection. We observed on both the top and first floor that food was simply put in front of people. Staff did not ask if people still wanted the food. A number of people did not eat what was given to them and staff simply replaced it with the second option available. Again some people did not eat this either. We did not see any alternatives offered.

Kitchen staff told us they got details each week of who had lost weight and took steps to ensure they received fortified drinks and additional high calorific snacks. However we found a number of people had lost significant amounts of weight and little productive intervention had been provided.

We reviewed the records held to support people in reducing the risks associated with malnutrition. We looked at risks assessments and care plans for people who had lost weight. We found care plans were well developed in identifying potential ways of supporting people. For example one described the person with a small appetite but likes to eat more often. It described their favourite meal and detailed other food that they liked. However the intake of these foods had not been increased and the person was still only receiving scheduled meals from the options available at meal times. There were no records to show anything had been offered in-between meals. The care plan had been evaluated and noted substantial and continued weight loss and noted the GP should be contacted for advice. But the risk assessment had not been updated and still identified the person at low risk. The risk assessment had not been updated with the new information. This person was not getting the support they needed to reduce the risks of malnutrition.

Another care plan identified the use of pictorial menus to aid one person's appetite and choice of food but these were not available. A risk had been identified that the person would get up from the table and forget they had a meal but a risk management plan had not been identified. This left a risk of this person's needs not being met.

We found staff offered support to people if they required it with eating their meals. However we noted each person's meal was delivered at the same time and those that required support simply waited. This meant that by the time the third or fourth person was supported that their meal was cold.

We found charts introduced to show how much people had eaten and drunk were limited in the information they provided. When people were at risk of malnutrition and dehydration these extra monitoring records were introduced. The records should clearly identify what people have eaten and how much. This helps staff understand what people like to eat to enable them to get more of what they will eat to reduce associated risks. We found these records simply stated, cereal, without saying which type or how taken e.g. with sugar and whole milk. They simply stated juice, not which type of juice or which type of pudding and so on. Records of this type need to be precise to enable them to meet their aim of reducing risks to people's reduced diet and fluid intake. We reviewed the fluid charts on the first floor on the second day of our

inspection. We noted records from the day before did not indicate people had received enough fluid. We looked at the records for nine people. The highest recorded fluid intake was 900mls the lowest was 400ml. The recommended daily consumption of fluid to avoid dehydration is 1200mls.

We discussed our concerns for two people with the manager who took immediate action to chase up information and actions from the GP.

We found when people had lost weight and they were at risk of malnutrition records were not updated to reflect the risks. We found when care plans were developed to support staff in how to reduce the risks, these were not always followed and we found when specialist support had been provided, it was not clarified or clearly recorded what was to be introduced. Where it was clear what was to be introduced, for example fortified drinks and shakes, there was not clear records to show when they had been given. We found inconsistent and poor recording of people's risks of malnutrition and a lack of appropriate action that could be monitored to reduce risks to people resulted in a breach of Regulation 14 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We found the home made referral to specialist services including the GP, falls team, optician and chiropodist as required. We recommend clearer records are held of the outcomes of referrals and if they are not responded to within a specific timeframe that a system is developed to chase referrals.

The building was purpose built as a residential care home and had extra design features making the environment pleasant and homely. However, more needed to be done in the design of the building to ensure those living with dementia were not frustrated by the lack of meaningful activity and engagement. We spoke with one person on the top floor who told us they were bored; one told us they felt like they were in prison.

We found corridors had dead ends and there were empty spaces in the middle of corridors which could have been made to appear more inviting or aesthetic to people who lived there. The wall covering and glass engravings needed more thought. We found the bathrooms had blue linoleum on the floors and when we discussed the impact of this with staff, we were told people think it is water. This is a common perception of blue flooring from people with dementia. The ground floor was homely and practical for the people being supported there. There was access to the garden which we saw used on both days of the inspection.

We did see that some work had been done to the signage in the home and each room had a memory box to help people identify their personal space. Some bedroom doors had been designed as a front door to help depict someone's personal living space. However there was no orientation information with the date, month and year available. There were no pictorial menus and records identifying staff, daily activities and the menu's for the day were incomplete or inaccurate.

We recommend the provider completes the Enhancing a Healing environment audit from the King's Fund. This will give the provider basic information on how to better design the home to meet the increasing needs of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

Everyone we spoke with on the ground floor was happy with the care they received. People told us the staff are caring and very friendly. When we asked one person if the staff were caring they told us, "Very, more than caring." Another told us, "Yes they are like friends, I feel like part of a family here." People on the upper two floors were more difficult to talk with but one person told us they liked the staff.

We saw one person being given a cup of tea in a cup and saucer. They were clearly having difficulties with managing the cup and saucer as they were lifting the saucer with the cup balanced on it to their mouth. This happened a number of times unobserved. We pointed this out to staff that went to attempt to support the person. However, the person was then left still with the cup and saucer and continued to drink as before. The staff member was unaware if the person was known to have difficulties drinking from a cup and saucer. This left a risk of the person burning themselves with the tea or dropping the cup from the saucer with the potential of breaking it. The person gave up and put the cup and saucer down without finishing the drink.

We observed lunch on each floor. It was a very different experience on each floor. On the ground floor where people had less needs the experience was pleasant and homely. People were offered a choice of jacket potato with various fillings or soup and a sandwich. People said what they wanted and it was given to them. On the first floor where people found it more difficult to understand the choices, staff were unclear on what was requested. As a consequence people were presented with a jacket potato with both beans, cheese, tuna and a slice of ham all on the same plate. Others were given soup and others had plates of sandwiches put in front of them. Some people had all the choices of food put in front of them one after another in a hope they would eat something. This clearly only aided confusion in one person who didn't eat much of anything.

After lunch we saw one person become a little agitated. The staff member attempted to calm them by asking them what they needed. The staff member asked them if they wanted a cup of tea, the response was no. They were asked if they wanted to go and have a lie down to which they replied yes. The person required the support of the stand aid and waited over 30 minutes for it. By the time the stand aid arrived the person had calmed but they were not asked if they still wanted to go and have a lie down. The sling was put around the person and they were told we are taking you for that lie down now. This person was clearly not expecting to go for a lie down by the time the stand aid had arrived but they did go without showing any signs of disapproval.

When people are not given choices in a way they understand about what they want to eat, what they want to do and when or people are not given opportunity to change their minds their personal preferences are not being respected. When staff do not mitigate risks to allow people to remain as independent as possible it is a breach Regulation 10 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We sat in on the handover from the night to day shift and saw the birthday of one person was discussed. We were told a cake would be presented to the person and people would sing happy birthday. Staff spoke fondly of the people in the home and shared genuine concern when people showed signs of being unwell.

We observed how staff interacted with people in the home and found them to be friendly. Staff and people in the home engaged in healthy banter and we heard laughter regularly throughout the inspection.

We observed the hairdresser interact with people on the day of the inspection and found them to be very pleasant in their demeanour. They supported people to the salon explaining they were going to be pampered and reassured people when they showed any sign of anxiety.

We saw people had newspapers delivered and observed people reading them quietly in the lounge. We observed staff supporting people to the dining room table in an encouraging and positive way.

People we spoke with felt involved with their care and felt they could influence it if they choose to. Four of the relatives we spoke with told us they had formally been involved in developing their family members care plan.

We saw the housekeeper knocking on bedroom doors and asking for consent to strip the bed linen for cleaning. We saw the housekeeper remove dirty linen from the floor and put rubbish in the bin of one room. This ensured the room looked its best for the occupant.

We saw people's rooms were decorated with their personal possessions, with photographs and family memorabilia.

We reviewed the files of three people who wore glasses and found they had them on as required.

People in the home were well presented and clean and tidy. Where people had accidents they were changed into clean clothing. The hairdresser visited weekly and people we spoke with enjoyed going to the salon to have their hair cut and or set.

Visitors we spoke with told us they could visit at any time with one visitor telling us they visited on Christmas day and had Christmas dinner at the home with their family member.

Staff told us they had completed the six steps end of life care planning and the trainer had taken steps to improve their own learning in advanced care planning which they planned to bring into the home shortly

Requires Improvement

Is the service responsive?

Our findings

People we spoke with on the ground floor told us there were a number of activities they could get involved with including quizzes, dancing and visiting entertainment. One person told us, "There was a big party for someone's birthday and we went to the garden centre." Another told us, "One staff member comes in and takes me out to the local market."

We found care plans to be difficult to follow. We saw assessments with no understanding of how they had been assessed. For example 'unable to shop for themselves, lacks the ability to care for their physical needs'. These were broad statements that were answered with yes or no. No actions were provided other than a list of care plans that the writer might want to update. Information was not person centred and were generally tick lists. Actions were generic, for example 'to monitor and ensure person is in an area where they can be observed'.

We found care plans were updated when reviews had not been completed and risk assessments reviewed and then care plans not updated. This meant there was inconsistent information about people's needs and how best those needs could be met.

In contrast we saw other care plans where specific risks had been identified that were completed in a comprehensive manner and included good assessment of both need and plans of care to meet those needs One person had become more aggressive and unpredictable as their dementia advanced. This person was now in receipt of one to one care. Plans had been developed to guide staff on how to support this person through different moods and states of mind including if agitated or if restless through the night.

However, some aspects of the care plan were as basic as others we looked at and it was difficult to ascertain if they had been followed or implemented. For example the communication care plan identified that the person should be seen by the optician annually but there was no detail of the last visit or when they were scheduled to visit again. The oral health care plan stated to refer the person to the dentist and again there was no evidence this had happened.

It appeared that those assessments and plans that had been developed more recently or updated following increases in need or changes in people's health were better presented and more person centred. We did find some assessments which didn't seem to make sense, for example identifying someone as low risk of malnutrition yet they were being weighed weekly for substantial weight loss. We also saw records stating the GP had been called and different teams were to visit people in the home for tests. Yet the date had passed and we could not see that these had been followed up. We saw some evidence within the home's diary and in the daily records but information had not routinely been added to the care plan or assessment updated following an expected visit. This included the expectation a district nurse was to visit to take some blood from someone to ascertain if the person was poorly as an explanation for weight loss. We discussed two specific concerns with the management of the home during feedback and immediately steps were taken to follow up on information and actions that had or had not been taken. We were contacted the day after the inspection and acknowledged steps had been taken in the right direction to ensure people received the

support they needed.

We saw plans of care that supported people at risk of pressure damage. We saw records stating to ensure people were turned through the night to relieve pressure damage but corresponding assessments identified the person at low risk of pressure damage and there were no positional charts available to show if the positional changes had taken place. There was no record in the daily notes but there were notes to show signs of pressure damage including redness.

We observed the use of specific aids to support people at high risk of falls including a portable sensor mat. We saw one person sitting on one during their lunch. The person attempted to get up and staff supported the person appropriately.

We found that when people's needs increased the home introduced additional monitoring to better support the individual, this included 24 hour observations which had details of where people were and what they were doing. There were daily mood charts which helped identify mood states from happy to unsettled, there was also scope for free text for the report to be more meaningful. We also saw records for monitoring people's food and fluid when they were at risk of malnutrition and records for monitoring people's position when they needed more support to reduce the risk of pressure areas.

It was clear some records had recently improved but some remained difficult to follow. We recommend the provider reviews the care plan records and ensures information remains relevant. We also recommend where assessments depict a level of risk that care plans clearly show how staff were to support that person to mitigate the risk.

When services do not have contemporaneous record of the support provided to people and records do not contain detail on decisions taken to support people it is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider group had developed an activity hub which other homes in the area had joined. This included organised monthly events outside of the home with other homes. Activities included meals out, trips to hotels and events which included, the golf open which was taking place at the time of the inspection. The activity coordinator told us the activity programme was flexible and was not regimented. We were told, "If people don't want to do one particular thing we won't do it and will try and do something people want to join in with."

When we looked in care plans we noted many identified people's preferences of what they liked to do, including spending time in the garden or listening to particular music.

People on the upper two floors told us there was no activities. There was a programme of activities but they did not happen. On the day of the inspection it was recorded that a coffee morning was to take place. We did not see any evidence of this on any of the three floors. On the second day of the inspection we saw afternoon tea being held in the garden which people appeared to enjoy.

We were told that the home did some good trips out to the community and that they had some good activities equipment. We were told it was people on the ground floor who benefited most from the activities.

On the first day of the inspection we found there were no activities taking place to stimulate the people living in the home. We had a dementia nurse as part of the inspection team who fed back to the staff on the floor supporting people living with dementia. They found they had to continuously prompt staff to engage

with people in a meaningful way. Prompts were given to support staff in how to engage people with activity that required minimal supervision but kept people occupied. We found the home had an activities coordinator who we saw arrived early on one the mornings. Yet we did not see any activities taking place until later in the morning and this was one to one activities including painting people's nails.

This was fed back to the management team and on the second day we saw better interaction. This included four people sat around a table with a box of jewellery. People had been told a staff member had lost a particular piece of jewellery and needed their help to find it. This was meaningful and the people were occupied and content for at least an hour.

We also found within an audit of the dining experience a suggestion from the newly appointed nominated individual that staff were handing our cutlery when the meal was provided. The nominated individual suggested that staff engaged with people in the home to lay the table prior to the delivery of the meal. This gave us some confidence that the home was becoming more knowledgeable of the needs of people living with dementia.

We reviewed the homes complaints policy and noted it was 18 months past its review date which was due in November 2015. We saw the complaints procedure was available in the service user information pack and was displayed on the notice board.

The complaints log only identified three complaints for 2017. There were none recorded for 2015 or 2016. However we noted in the file there was some brief information about a complaint raised in November 2016.

The policy identified how people should complain and detailed response times and who to contact in the event the complaint was not concluded to the complainants satisfaction. It correctly identified the Local Government Ombudsman but did not provide contact details.

The three complaints held within the file did not follow the guidance also held in the file. There was a clear complaints form which was not used and also a blank spreadsheet to record the various stages of the complaint handling system which was not used. The spreadsheet included accountability of the complaint at the different stages within the process. This meant from reviewing the available information it was difficult to ascertain if a complaint had been closed and if the response had been accepted as satisfactory. The policy stated all complaints would be responded to in writing but there was no evidence in the file that this had happened. We were also aware of one other complaint which was held in the manager's file which had not been included in the log and managed in line with the procedure and we noted others from care records and daily logs.

When services do not have a current policy and procedure that is followed then there is not an accountable system for receiving, handling, reporting and learning from complaints. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires Improvement

Is the service well-led?

Our findings

People in the home and visitors knew who the manager was and told us they were often seen on the floor on the home. People we spoke with told us the manager was approachable

The system of quality assurance at the home at the time of the inspection was ineffective. The developed audits were not consistently completed and there was not a clear procedure for monitoring the delivery of the regulated activity. We could see new systems and procedures were beginning to be introduced but the impact of these was yet to be seen. Quality visits had been undertaken by the management team and these included a high level review of the service. Any actions from this were then transferred onto the home's development plan. This system provided good oversight but the monitoring and audit processes to underpin this was yet to be fully embedded.

The monthly audit file did not contain monthly audits. There was a list of policies and review dates. It was difficult to measure the purpose of the information as no actions had been identified and many had not been completed since 2011. As the home had not opened until 2014 it could only be concluded that the policies had been adopted from a different service and had not been updated to reflect Abbey wood.

We saw a number of risk assessments had been completed on the environment and the building. These had mainly been completed in early 2016 and were past their annual review date. We saw that when risks were identified basic mitigation had been provided but no monitoring was completed to ensure the risks were being managed. For example there was not a monthly review of the risks to the building as was required within the health and safety policy. This included risks to slip, trips and falls, contact with cleaning chemicals, electric shock. We also reviewed a security risk assessment which was clearly for a different building as it identified a gated property with flood lighting and coded access. There were no such arrangements at Abbey Wood lodge. We reviewed the risk assessment for the kitchen. The assessment appeared to be incorrect. The risk of cuts and burns was assessed as low with a control measure of equipment and first aid training. A major incident was measured as a medium risk and the control measure was procedures in place. Following the inspection and on production of the draft report a much more comprehensive assessment was provided, which was fit for purpose. On the days of the inspection we found the risk assessments in place for the management and delivery of the regulated activity to be less than sufficient.

People on the top floor of the home were mostly living with advanced dementia. Staff and people living on this floor were vulnerable to both verbal and physical attacks. We spent a lot of time on this floor and it was clear a number of people were unpredictable due to their condition. Staff told us they felt unsafe at times and people we spoke with identified the people who they were afraid off. We looked at the procedures the home had in place to protect both the staff and people on this floor. There had not been a risk assessment to ensure people were protected and there was not any training for staff to better support people that may pose challenges for them. Two staff members told us that other staff refused to work on this floor because they felt at risk.

The inspection team identified a number of concerns which had not been identified by the management team. This was due to a system of quality audit and assurance not being effectively implemented. Systems were being developed and procedures were beginning to be implemented but at the time of the inspection the service remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had a file which they used to hold all the current information about the home; it also contained the most recent audits and details on staff and people living in the home. We found a number of pieces of information within the file which would be used to update other records at the end of each month, for example there was a complaint that would be added to the complaints log and information to be included in the complaints file. There was a list of staff that had been booked onto training which would be added to update the training matrix.

We also found details of audits that identified concerns in the management and handling of medication that had not been actioned. We recommend the manager ensures that information does not get lost in the detail of this file and actions required to improve service delivery and safety are implemented in a timely manner.

Prior to the inspection we had received concerns around the fees people were paying and on the day asked to review the fees policy. One could not be found, We asked to see the contracts the provider had with people living in the home for fee payment. There was not a contract available.

We found people were paying very different amounts for similar support and accommodation. We also found that there was not a fees policy or framework in place.

We were shown pages from the service user introduction pack which identified the fee payable for that particular individual. We discussed this with the provider and there was not a reasonable explanation provided as to the different fees payable. There was a brief statement as to what was provided in the home but this was not clearly defined based on the individual and a statement of either the fee payable or the terms and conditions for their specific residency at the home. The service user guide included a brief procedure explaining that fees would be reviewed annually or when changes were made to the service plan. It is unclear what this meant. It also noted people would be given one months' notice in the event that fees would increase. One person's relative who lived in the home told us their fees had increased without any explanation on two occasions since they family member had lived in the home.

People in residential care settings are vulnerable by their very nature. Providers are required to have clear details around the costs of care and the terms and conditions of care provided. Written information about fees should be available. This would allow people to be aware of what and why they pay what they pay and when and why it will increase or decrease. For this to not be clearly defined in a statement of costs and terms and conditions is a breach of Regulation 19 of the Care Quality Commission (Registration) Regulations 2009.

There were people on all three floors of the home that required the support of equipment to mobilise. However there was only one stand aid in the building. We observed two occasions where the stand aid was required to support people and it was not available. We observed on both occasions people wait longer than 20 minutes for the aid to be available. We recommend the provider ensures there is enough available equipment to meet the needs of people living in the home

During the inspection the inspection team looked around the building to ascertain if the ratings from the previous inspection were available. We did not see them. Following the inspection we were provided with

evidence to show they were displayed for people to see. We had looked at the provider website prior to the inspection and whilst writing this report and found the ratings for the previous inspection were not displayed. However these have also been added following receipt of the draft report. We recommend the provider ensures the information and ratings available on both the provider's website and displayed at the home are the findings from the most recent inspection.

The manager had registered with the commission in April 2017 but had worked at the home for approximately 18 months prior to that. From beginning in post the registered manager opened different avenues of communication with staff, including memos to share important information, whilst at the same time beginning to embed staff meetings and supervision. We noted on the day of the inspection that a team meeting and supervision schedule was now developed. Different meetings had begun to take place to review the health and safety of the building, for kitchen staff, senior staff and all care staff.

We noted a number of questionnaires had been distributed shortly after the manager had started to staff members, relatives and supervisors. The results were predominantly positive.

Staff were aware changes were beginning to happen at the home. The ethos and culture of the service was beginning to change, with the introduction of a new senior leadership team. Staff spoke highly of the manager and said they were very supportive. Regular meetings were held to discuss organised activities

The home had begun to introduce a 'This is me' document for staff. It included a picture, the staff members name and some basic information about them. This included details of their family life and likes and dislikes. These were to be displayed across the home for visitors and people in the home to read at their leisure. This was also a good way for staff to be more accountable as visitors and visiting professionals would be more readily able to identify them if they needed to report any concerns.

It was clear the home was going through a period of change. The staff team had been unsettled and there had been a high turnover of staff including two managers in the past two years. Systems and processes were being developed and procedures had just begun to embed. However inconsistencies remained and the management team were aware a consistent and constant approach was required to move things forward.

People we spoke with raised similar issues and concerns. People felt that improvements had been slow to start and they remained frustrated at the lack of activities and the time it took to get things done.

Staff told us the manager was approachable and we could see from meeting minutes conversations were constructive. Staff felt comfortable to air concerns and issues within the meetings. The manager completed walk arounds of the home and also undertook unannounced night visits. One had been completed this year.

We saw the home had started holding meetings for people living in the home and their relatives. These had begun in May 2017 and we saw a timetable of meetings scheduled for the year available in the foyer of the home. The meetings were held for views to be shared on the provision from the home, to share information about events and activities and for both the management and people in the home to work together to make recommendations and improvements.

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 19 Registration Regulations 2009 Fees Regulation 19 (1) (a) (2) (a) The provider did not have a written and available copy of the terms and conditions and details for fees payable

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (b) The provider was not routinely offering appropriate support to ensure people could maintain their autonomy and independence. This included mitigating any associated risks and acknowledging people's expressed wishes. Staff appeared unable to communicate effectively with some people to allow them to make informed choices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) Consent was not always acquired before the delivery of care and treatment. Consent was not always acquired from those with the authority to give it and consent was not always acquired in line with the Mental Capacity Act

2005

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 RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (i) The registered provider did not have an effective procedure to protect people in the event of an emergency. Regulation 12 (1) (2) (b) The registered person did not have effective systems to protect people from assessed risk. We found assessed risks were not managed appropriately and identified action to reduce risks was not always undertaken. We also found that risks had not always been identified. Regulation 12 (1) (2) (g) The provider did not follow safe procedures for the recording and management of medicines.

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 RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) (4) (b) The provider did not report potential safeguarding alerts to the Local Authority to receive support required. Restrictive practice was not assessed and managed in line with the Mental Capacity Act 2005.

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 RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (1) The provider did not have effective systems in place to ensure risks to people's nutrition and hydration were consistently met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2) The provider did not have effective systems in place to manage, investigate, respond and learn from complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) the provider did not have systems to monitor and improve service provision. Risks that had been identified were not appropriately mitigated. Contemporaneous records were not kept to ensure the people living in the service and staff working in the service were kept safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) the provider had not taken appropriate steps to

ensure that suitable numbers of skilled and competent staff were deployed to meet the needs of people living in the home.