

Ashley Down Care Home Limited

Ashley Down Nursing Home

Inspection report

29 Clarence Place
Gravesend
Kent
DA12 1LD
Tel: 01474 363638
Website: N/A

Date of inspection visit: 7 January 2016
Date of publication: 23/05/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

The inspection was carried out on the 7 January 2016 and was unannounced.

Ashley Down Nursing Home provides accommodation for up to 19 people over the age of 65 that may require nursing and personal care and support, some of which may have dementia or a physical disability. The accommodation is provided in a older style detached house in a residential street. There is a communal lounge,

dining room, kitchen, communal bathrooms and bedrooms with ensuite bathrooms. Outside there is a good size garden that people have access to. There were 16 people living in the home when we inspected.

At our previous inspection on 15 and 16 December 2014 we made reference to a number of areas for improvement. The fitting of a stair gate was still required. The assessments to make sure that the use of bed rails did not restrict people's freedom unlawfully were still in progress. Essential training such as end of life care had not yet been provided for all care staff. Regular one to one

Summary of findings

supervision for all staff and annual appraisals had not yet been provided. Plans to improve the format of all information for people in a larger and pictorial format had not been implemented. Activities did not meet people's needs and preferences. Improvements to the management systems and the actions that had been taken as a result were not yet embedded into the practices at the service.

At this inspection, we found that some improvements had not been made since the last inspection. However, some of the areas for improvement had not taken place.

The registered provider was also the registered manager, who was in day to day charge of the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe in the home. Relatives also told us they thought their relatives were safe and care was provided appropriately.

Recruitment practices were not always robust and we found one person working in the home without a Disclosure and Barring Service check. Nursing staff had checks carried out on the professional registration with the Nursing and Midwifery Council (NMC) but the registered manager had not implemented suitable checks to monitor when these were due for renewal.

People and relatives told us they didn't feel there was enough staff deployed to meet their needs. Staffing levels had not been increased despite a recorded increase in dependency levels.

Staff were receiving supervision but not in line with the provider's policy. Some staff told us that the manager was approachable and that they felt supported. Other staff said that they didn't feel listened to. We made a recommendation about this.

Staff had completed training in the Mental Capacity Act 2005 but there was no evidence that this training had been embedded in every day practice of caring for people. Staff had not received training in Deprivation of Liberty Safeguards (DoLS). We have made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS applications had been made to the local authority and had been approved. However the registered manager has failed to notify CQC of the authorisations.

The environment of the home had not been adapted to make it more suitable for people living with dementia. We have made a recommendation about this.

The registered manager frequently worked care shifts and not supernumerary therefore did not have the time to complete their role and responsibilities as the manager.

The home had systems in place to audit and monitor the quality of the service. However, these were not robust and did not demonstrate that improvements had taken place as a result.

The provider had put into place new policies and procedures but they had not established that some of them were not fit for purpose. Some policies could not be practically implemented and the registered manager was unaware of the content and details of other policies which conflicted with practice.

There were no meaningful activities taking place in the home. People told us that there was nothing to do and no one to talk to. There was a lack of stimulation and people were at risk of social isolation.

People had opportunities to feedback about their care and support. However 'Resident's survey's' showed that specific requests had not been responded to.

There were risk assessments in place that were personalised to people's needs and updated as their needs changed. However, there was little evidence that people had been involved in the drawing up or review of their care plans.

There was a complaints policy in place. However, one person was still waiting to receive support with the issues they had raised.

The security of the home had been improved as well as the surrounding perimeter of the garden.

There was a safeguarding policy in place that made reference to the local authority's policy. Staff had received

Summary of findings

training in safeguarding and were able to describe what they would do in the event of any safeguarding issues occurring. Staff knew about the whistle blowing policy, why and how to use it.

People had personal evacuation plans and staff had received fire training and knew how to support people to evacuate the building in an emergency.

People were supported to receive their medicines on time by qualified and competent staff. Medicines were managed and stored appropriately.

People were encouraged to maintain a healthy diet. The kitchen was well stocked and people told us they enjoyed the food. People had access to drinks and snacks throughout the day.

People were supported to access health services and their health care needs were being met.

People told us that staff were caring and we observed staff engaging with people in a kind and compassionate

way. Relatives were able to visit their relatives when they wanted to. Care plans were individualised and people's likes and dislikes had been recorded. Staff knew people well and treated them with respect and dignity. People and staff records were kept confidentially and could only be accessed by those authorised to do so. People's rooms had been personalised and some people had their own furniture.

There was a service user guide, but this was not available in other formats that might be more suitable for people's needs.

There were 'residents meetings' held which all people were encouraged to attend. People had been consulted about recent redecoration works and chosen colours. People told us they thought the home was well led.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe

There was not enough staff to meet the assessed needs of people. Effective recruitment procedures were not followed.

There were safeguarding adult's procedures in place and staff knew how to recognise abuse and what to do should abuse occur.

Risks to people's safety and welfare were well managed to make sure they were protected from harm.

There was a medicines policy and procedure in place and people were administered medicines by staff that were competent and qualified to do so.

Requires improvement



Is the service effective?

The service was not always effective.

Staff did not have a clear understanding of the Mental Capacity Act and the principles behind Deprivation of Liberty Safeguards and how they should be applied to support people living in the home. Regular one to one supervision was not taking place.

Decoration of the home did not follow good practice guidelines for supporting people who live with dementia.

People's health needs were being met and medical intervention was being sought when needed.

People had access to food and drink throughout the day that met their needs and choice was available.

Requires improvement



Is the service caring?

The service was caring.

Staff treated people with respect and dignity. People's privacy and dignity was respected. People's confidential information was securely kept.

People were consulted about how they wanted their care delivered.

People were encouraged to maintain relationships with friends and family.

Good



Is the service responsive?

The service was not consistently responsive.

There were no meaningful activities taking place in the home.

It was not clear if people had been involved in their care planning.

Requires improvement



Summary of findings

There was a complaints procedure in place but not all the details were current and up to date.

People's and relatives views were gathered but feedback had not always been acted on. People were consulted on the décor of the home.

Is the service well-led?

The service was not well led.

Systems to monitor the quality of the service were not effective and were not conducted in a timely manner.

Issues that were the responsibility of the registered manager and provider were not being dealt with in a timely manner.

The registered provider/manager spent time working on shift as a nurse which took them away from their management responsibilities.

People thought the home was well led. Some staff though the home was well led and they spoke of an open and supportive culture.

The registered provider was not aware of the contents of some of the policies and procedures that they had put in place and had no real over sight of the running of the home.

Requires improvement



Ashley Down Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 January 2016 and was unannounced. The team consisted of two inspectors, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor had expertise in caring for older people.

Before the inspection we reviewed previous inspection reports and notifications. A notification is information about important events which the home is required to send us by law. We looked at safeguarding and whistleblowing information we had received.

We spoke to nine members of staff. This included the registered manager, one qualified nurse, three care assistants, kitchen and domestic staff. We spoke to 10 people living in the home and one relative.

We observed care and support being provided. We looked at records held by the provider and care records held in the home. This included five people's care plans, risk assessments, staff rotas, staff recruitment records, meeting minutes, policies and procedures, satisfaction surveys and other management records.

Is the service safe?

Our findings

People told us they felt safe. One person told us; “Safe. Of course it is, nice staff who treat me well, staff do everything nicely, they always come in and say hello”. Another said it’s “Very safe. Staff are very attentive here, they come when you buzz for help, about 22 seconds, I have timed them”. A relative told us “Yes I feel it’s safe here for my relative, I come here regularly and the staff are always very attentive to residents when I am here”.

The provider had a recruitment policy in place but recruitment practices were not effective. Checks were made on staff to make sure that they were suitable to work in the home and were of good character. Staff had been vetted before they started working at the home through the Disclosure and Barring Service (DBS) and we saw evidence of this on staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There was one staff member who worked in a non caring role that had not been subject to a disclosure and barring service (DBS) check, even though they had had contact with people living in the home. The registered manager confirmed that this check had not been completed and advised that they would apply to have this check completed as soon as possible.

The provider employed four nurses and checks had been carried out concerning their professional registration with the Nursing and Midwifery Council (NMC) when they were recruited. However, there were no systems in place to monitor their registration and the registered manager relied on nurses to alert them when their registration had been updated. This meant there maybe a risk that nurses could be employed with the home without appropriate professional registration.

Failure to check that staff were suitable to work in the home was a breach of Regulation 19 (1)(a)(2)(a)(3)(a) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

Staffing levels in the home were not always adequate to meet the needs of people. One person told us, “The staff do the basics like washing me and getting me food and drinks, they always get things done. They don’t have time to come in and sit and chat. Since they have had additional residents they have had no additional staff. The manager

has told me that they have been interviewing for new staff”. One relative told us, “I visit regularly and always see staff about. I think with the pressure of residents they could do with one or two more staff”.

A dependency tool was in use and the level of support required by people who lived at the home was monitored on a monthly basis by the registered manager. This had been completed every month from April 2015 until October 2015. The tool showed that all of the people who lived at the home had experienced increases in their level of dependency and the support they required. Records showed that for three people there had been significant increases in the level of support they needed. Rotas showed that there was a consistent level of staffing numbers being maintained despite the increased level of dependency of some people. However, the dependency of people had not been taken into account. Steps were being taken to recruit more staff for the home and we were told by the registered manager that three new staff were due to be starting as soon as their DBS checks had been completed.

We observed that documentation had been consistently completed by one member of staff. The staff rotas showed that this member of staff had not had a day off since 26 October 2015. We spoke to this member of staff and they told us they were concerned about what wouldn’t happen if they did not come into work. We spoke to the registered manager about this and they told us, “I can’t stop this person working, it is their choice”. The registered manager and provider was not taking into account the welfare of its staff or ensuring staff took adequate breaks for their own health and safety.

There were not enough qualified nursing staff to support the needs of people. This was a breach Regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises were secure and the home had an alarm system which would alert staff if an intruder attempted to enter the building. Additional steps had been taken to ensure that the garden was secure and new gates had been installed. There were plans to install a digital lock for the home for increased security. This enabled people to mobilise around the home and garden without being restricted unnecessarily.

Is the service safe?

The provider had a safeguarding policy in place which made reference to the local authorities safeguarding policy. It gave detailed steps on what staff should do to protect people from potential abuse and what to do if they had any concerns. This policy was available in the office for staff to refer to if required and they were aware of where it was kept. Staff told us they would speak to the registered manager or nurse if they had any concerns. One member of staff told us, "I would phone social services if I had any concerns". Records confirmed that all staff had received training in safeguarding. The home had a whistleblowing policy in place and staff were able to tell us why they might need to use it and what the procedure was. Effective procedures were in place to keep people safe from abuse and mistreatment.

People had individual personal emergency evacuation plans (PEEPs) in place. Staff were trained in fire evacuation procedures and knew what they should do in case of an emergency. Training records showed that all staff had received training in fire awareness. Fire protection equipment was regularly checked and maintained. Staff were able to support people to evacuate the building in the event of an emergency situation.

There were environmental risk assessments in place as well as a maintenance log. Electrical appliances were regularly checked to make sure that they were safe to use. There were water hygiene audits in place. Staff were responsible for running unused taps for four minutes every week in order to flush water through the system which had been a recommendation from a Legionella risk assessment. The records had been signed to confirm this had been done. However, they were also signed for a date in advance of the day we inspected so it was unclear if this check was being carried out or not.

Care plans contained risk assessments individual to people's needs. These included risk assessments for falls, use of bedrails, wound care and skin integrity. Risk assessments were reviewed and updated as and when people's needs changed and were seen to be personalised to each person. The plans were detailed and of a high standard and updated by the qualified nurses on duty each day. We did observe that one nurse appeared to be responsible for this recording over the last four months. Staff were able to provide care which was safe and met each person's needs.

The home was suitably clean and was free of unpleasant smells. The provider employed two housekeepers who followed a detailed cleaning schedule. People told us that the home was clean. One person said, "My room is cleaned every day, my room is vacuumed every day and bedding is changed every week. The cleaner is very good". A relative told us, "The home appears well maintained and always looks fresh and clean. My husband gets his room cleaned every day. The cleaners are very good". The provider had made appropriate improvements since our last inspection.

People were protected from the risks associated with the management of medicines. Medicines were stored appropriately within a locked trolley and clearly individually identifiable per person. The fridge used to store medication was locked and a daily record made of the temperatures. However, the room temperature to store the medication trolley was not regularly monitored or recorded which could pose a risk if temperatures exceeded normal levels. We noted that this was not an issue on the day of our inspection but the provider may wish to consider monitoring the temperature of this room throughout the year.

The systems in place for ordering of medicines were appropriate and utilised a local pharmacy provision. There was a repeat prescription system that provided a four week dosette box and medicines were prescribed, ordered and administered in a timely fashion. A dosette box is a box containing all the medicines required for a person for the month, with date and times to be given. They are prefilled by the pharmacist. There was a register of nurse's signatures and initials which included details of agency staff. The staff rota showed a safe compliment of qualified staffs in order to complete the medication round and ensure people received their medicines as prescribed.

Medicines in stock tallied with the Medication Administration Records (MAR) charts. The medicines disposal and refusal register was also accurate and correlated with entries in the MAR charts. There were effective systems in place to regularly check medicines. This was recorded in a hand over record which had been completed when two staff were present and had been confirmed by the nurse.

A nurse was responsible for the administration of medicines and was observed to check with each resident and follow accurately each step of the administration process. One person told us "The nurse always pops in to

Is the service safe?

give me my medicine morning, lunchtime and evening. I have never had to remind staff". The nurse commented that, "The MAR system is easy to follow", when asked about how new staff would find the process, the nurse explained that "Each resident has an individual MAR chart, this included information such as photograph, swallowing ability, compliance, thickening requirements and any

allergies or reactions". Staff we spoke with demonstrated an awareness of processes to report medicines errors if it occurred. There had been no medicines errors recorded. This meant that people received their medicines from staff who were competent and confident to administer medicines safely.

Is the service effective?

Our findings

People told us that staff cared for them in the way they preferred. One person told us, “Staff wash me every day and I shower or bath every week. They help me to get dressed”. Another person said, “The carer always ask me what I want to wear and lets me choose the clothes I like”. A relative told us their family member “Always made decisions in their work life. Despite their health they are quite able and want to make their own decisions about their care. They are always well groomed and say they are happy here which is positive”.

Staff told us that they had completed induction training when they started work in the home. Staff told us that they received supervision on a regular basis. This had been carried out by the administrator for the service. Some staff had regular supervision, however, not all staff supervision was up to date and the staff member carrying out the supervision had not been working in the home for two months prior to the inspection. The homes policy on supervision stated that new staff members would be supervised on a weekly basis. The registered manager confirmed that this had not happened and that staff were receiving supervision every eight to twelve weeks. Clinical supervision was provided for the nurses by the registered manager. The support structures in place for the qualified nurses did not include any external peer support. We spoke with the registered manager about this. They told us they would be put in place additional peer support for nursing staff following the inspection. Staff were not receiving support in line with the provider’s policy.

We recommend that all staff receive regular supervision and guidance to enable them to carry out their roles effectively.

Staff had received training considered mandatory by the provider in areas such as moving and handling, infection control & food hygiene and this training was up to date. Records showed that most staff had completed training in end of life care. There was an end of life pathway for staff to follow that gave directions on what to do and the appropriate time. There was an end of life policy that was available for staff to consult. Staff had been given suitable support and information in order to provide care and support for people at the end of their life. Staff had received suitable training for them to safely carry out their role.

Staff had received training in the Mental Capacity Act (MCA) 2005 and best interests decisions were documented in people’s care plans. However, staff we spoke with were not always clear about the process for making decisions when people lacked capacity to make their own decisions. One staff member told us, “The manager makes the decisions”. They did not show any awareness of the process for making a best interests decision and who this may involve. Another staff member told us that they would look at care plans in order to know if a person had capacity or not but they did not understand that capacity assessments were not in relation to all decisions but specific to particular issues.

There was no evidence that staff had completed training in Deprivation of Liberty Safeguards (DoLS). Despite this there were DoLS checklists in people’s care plans and DoLS had been applied for by the registered manager for some people. Authorisations had been received after being granted by the local authority. The registered manager had taken into consideration people’s ability to consent to things such as the use of bed rails. Care plans documented best interests decisions in relation to this.

Some people at the home were living with dementia. We found the environment had not been designed with the needs of people with dementia in mind. There was a lack of signage or other information that would help people with dementia to move around the home. The day’s menu was displayed on the dining room mantelpiece. It was not in a format which was easy to read unless you were standing directly in front of it. A relative told us “I have never seen the menu displayed. My relative cannot remember what they have eaten and if it was clearly displayed on something like a white board we could talk about the meal”. We spoke to the registered manager about people living in the home with dementia. They told us they thought there was one person that was showing signs of dementia, but no one else. This person’s care plan evidenced a diagnosis of dementia. People living with dementia may not be fully supported in the home’s environment.

We recommend that the registered provider follows good practice guidance to make adaptations to the premises to support people living with dementia.

People were encouraged to maintain a healthy and nutritious diet. People told us that they enjoyed the food. One person told us, “I suffer from some food intolerances. They have been brilliant here, fabulous at working with me

Is the service effective?

on my diet which works for both us. There are quality products and good preparation here. I supplement with goats milk". Another person told us "They let me eat when I want to and let me take as long as I like".

The kitchen was well stocked and the cook confirmed that there was a sufficient budget to provide plenty of food. Food was properly stored and opening and closing checks were completed and documented to show that cleaning had been completed and checks made. The home had ordered a hot trolley, this was being introduced to ensure that food was served hot during meal times.

Cold drinks were always available for residents in the lounge and in their rooms throughout the day. We observed that people were offered their choice of hot or cold drinks and being offered biscuits. One person who was unable to hold their cup was offered their drink in a beaker with a straw. The staff member sat down beside them encouraging them to drink. The cook offered a choice of two main dishes for the lunch time meal. This was discussed with people when they were having their morning refreshments.

People's weights were monitored by the nursing staff on a regular basis and referrals were made to dieticians if necessary. Some people required support with eating and drinking and we saw

one person who was cared for in bed had their food served on a plate with different sections to enable them to have food items separately which suited their needs. Other people had plate guards to help them eat independently.

People were supported to maintain good health and had access to health care services. People were registered with a GP and visits were recorded in the plans. People also had access to other specialist healthcare professionals such as dentists and opticians. One person told us, "The doctor has been to see me two or three times since I have been here and prescribed some medicine. If I don't feel well I tell the staff. The nurse seems to know when I am not well and always comes in to check to see if I need the doctor". Another person told us "The doctor has been in to see me for a review. I have had a blood test done". Staff recognised that the people's healthcare needs could change and demonstrated awareness of what to do if they noticed a change. This meant that people's health care needs were being well met.

Is the service caring?

Our findings

People told us they thought the staff were kind and caring. One person told us, “Staff are very kind and caring, considering what they have to do, they manage very well”. Another person told us, “Staff are very good and aware of what I need”.

We observed a reassuring interaction between one person and a nurse. The person was becoming anxious about whether their relative would visit and asking staff if they knew. The nurse took time to reassure them and asked if they would like her to give their relative a call to check to see if they were visiting. The nurse went straight away to make the call and came back to tell them their relative would be visiting and would be there before lunch. The person immediately relaxed and thanked the nurse for checking. One relative then told us “Staff are very caring. When my relative wanted to know if I was visiting today the nurse telephoned me to check and was able to give them some reassurance”.

We observed that one person who was brought down to the lounge turn very pale. The staff member immediately asked them if they felt okay and they said they felt sick but would be all right. The staff member immediately reported this to the nurse and brought back a glass of water to sip and a bowl. The nurse stayed with the person until their colour returned and they felt better. Staff were mindful of people’s wellbeing and were kind and compassionate and responsive to their needs.

Support for people living in the home was individualised and care plans recorded people’s likes and dislikes and individual preferences. There were details of people’s personal histories. Staff told us that they knew the residents well and had a good understanding of personal histories and preferences. One member of staff told us, “I like getting involved with the history of residents, it helps me with looking after them and gives me a chance to talk to them about their past”. Care plans were updated and reviewed regularly but only one of the five care plans had been signed by the person indicating they had been involved in the review. The staff demonstrated they knew people well and had spent time getting to know them.

Staff treated people with respect and dignity. They knocked at the door before any room was entered and they waited for a response. One person told us, “They [staff] always knock on the door before they come in. I get on well with staff. They treat me with respect”. A relative told us, “We are treated with respect and dignity. Staff always knock before they enter the room. They are always polite”. This meant that people’s dignity and respect was upheld by the staff. People were encouraged to be as independent as possible. Staff told us “We encourage people to do as much as possible”. Another member of staff said, “I am not allowed to take away their independence”.

People’s rooms were personalised and several people had their own furniture. One person told us “I never worry when I need anything, my room has everything I need and I love my own pictures and bits and bobs”.

People were provided with information about the service when they moved into the home. There was a service user guide that had been updated in September 2015. This had pictures of the home including the bedrooms and communal areas. It gave details about what people could expect living in the home and its purpose. This meant that people had up to date information about the home.

People’s information was treated confidentially and their personal records were stored securely. Staff knew not to have confidential conversations in communal areas. They told us they would use the office or in the person’s room. Relatives told us, “I have not heard staff discussing any confidential information about other residents. When we have had to discuss anything we have been taken into the nurses’ office”. Confidential care plans, notes and records were kept in locked filing cabinets in the nurses’ office which was locked when not in use. Staff files and other records not required on a day to day basis were securely locked in cabinets within the registered manager’s office to ensure that they were only accessible to those authorised to view them.

Relatives confirmed that they were able to visit their family members when they wished to and stay as long as they wanted. Throughout the day relatives visited their family members. People were supported to maintain relationships with friends and family.

Is the service responsive?

Our findings

People told us that the staff were responsive to their needs and they knew how to make a complaint if they needed to. People told us that although they may not have made a complaint they knew how to raise an issue. They told us the registered manager often asked them if they were happy in the home. There was a complaint policy on display in the entrance lobby of the home, however, one person told us, “There is no procedure for complaining. I haven’t seen one but if I have an issue I speak to the manager straight away”.

There was a complaints policy and procedure in place which gave clear guidelines on how people could complain and information on when they could expect a response. It did not contain details of who people could contact in the event that they were unhappy with the homes response to any complaint. The homes statement of purpose contained details of the local authority but these were not up to date. It did not contain details of the Care Quality Commission (CQC). Records showed that a complaint had been made by a relative in July 2015 in relation to oral care for a person who lived at the home. We spoke to this person and they told us that they were not receiving support with oral care. The registered manager had not responded appropriately to complaints made by people.

This is a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were no meaningful activities taking part in the home. There was an activities board displayed in the entrance hall. It was easy to read in picture and text format. On the day of the inspection there were no activities displayed. On another day the activities listed was the hairdresser in the morning and tea and chat in the afternoon. Later that week the chiropodist was listed as visiting in the morning. At the bottom of the chart there was a list of forthcoming events which had not been allocated to any days of the week. There was an activities coordinator who had a dual role as the home’s administrator however they had not been working in the service for two months and activities had not been arranged that suited people or based on their preferences.

We spoke to several people and they told us, “There is nothing to do or too talk to. The manager tells me that they are recruiting an activities co-ordinator which will be

good”; “Staff used to take me outside when we had nice weather but I usually sit here in the lounge”; “We sometimes play games like I spy. There is no one to sit and talk to”. We spoke to the registered manager about the lack of activities and they told us they were looking to recruit a new activities coordinator but that there had been nothing put in place whilst the previous coordinator was not working. People living in the home were not participating in meaningful activities and meant they might be at risk of a lack of stimulation and of social isolation.

We looked at residents questionnaires and noted that one person had asked to be in the lounge with other people. We checked the daily notes for this person and they had not been out of bed for a week at a time. We asked the registered manager about this and they told us they were uncertain why this person had not been out of bed but thought there might be for clinical reasons. One person we visited on the ground floor was cared for in bed. The room was large and it had only one window which faced a brick wall. There were no pictures displayed on the walls. They told us that they used to be in a room with two windows and had a view and the room was light. They said “I am lying here every day and I would like to sit in an easy chair. The only chair in here is my commode”. When we spoke to the registered manager they told us that people had a radio and televisions in their rooms. The home was not providing care that suited people’s needs or reflected their preferences.

This was a breach of Regulation 9 (1) (a) (b) (c) (3) (b) (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans had been reviewed on a regular basis in line with people’s changing needs, this included changes to medicines and change of manual handling requirements. Some of the care plans had been signed by people, but there was no evidence to show where people or their relatives had been involved in their care planning. We spoke with staff about whether people were involved in care plans and they told us, “Care plans are done with people but we don’t record these conversations”.

We recommend that the registered manager puts into place a system of recording people’s involvement of their care planning and reviews.

Residents meetings had been held, the last one on 1 December 2015. The meeting minutes evidenced that

Is the service responsive?

people who were cared for in bed were visited on an individual basis to discuss agenda items from the meeting. This meant that all people had the opportunity to participate in the meeting and have a say in what was happening in the home. In this meeting it was noted that people were asked if they had any complaints about the service. One person said of the food and menu, 'I get more

than enough to eat and I can choose from the menu'. The home had recently had some redecoration works carried out. The meeting minutes evidenced that people were asked to choose which colours they would like the lounge and dining room. People were given a choice and were able to have an input into changes and improvements in the home.

Is the service well-led?

Our findings

People told us they thought the home was well led. One person told us, “The manager’s okay, they always listen and has told me I am going to have new flooring in my room. I am asked them, is it going to be slippery and they said it will be easier for me in my chair and will look good and I should have no problems”. Another person told us, “The manager asks if I am happy. I am very happy here.” A relative told us, “We have only been here a short time but family and I seem to think it is alright. Any questions we have asked have always been answered straight away”.

Some staff we spoke with told us that they could speak to the registered manager and they were able to approach the nurse if they had any concerns. Staff described the culture of the home as open and said they could request help and report problem openly. One staff member said “If I made a mistake I will tell the nurse and I will get support”. Another staff member told us, “There’s a good culture in the home and you can always speak with the manager”. This positive view was not always consistent. Another member of staff told us, “I don’t feel as though I am listened to and I do not want to make any suggestions to the manager”. The last staff meeting had been held on the 12 December 2014. Staff were not given the opportunity to voice concerns or views other than in supervisions. However, supervisions did not occur on a regular basis to enable staff to voice their concerns or make suggestions in a confidential environment.

Staff were aware of their roles and responsibilities in providing support to people. Staff spoke of an open culture. One member of staff told us “Things are getting better. We need a staff communication book. We are a small care home, the problems are from day to day and we just sort things out. We just get on without jobs”. Another member of staff told us, “I like working here, it’s been nearly three years, we’re a good team”.

The registered manager was also the registered provider. They told us that they were always available. Staff told us that they could always phone them if there was a problem. The registered manager told us that they worked on shift as they were also a registered nurse. They told us that they were supernumerary on an ad hoc basis. Staff rotas showed that when the registered manager had worked on shift they were not supernumerary as they were the only registered nurse on duty. The provider’s statement of

purpose confirmed that there was one registered nurse on duty throughout the course of a 24 hour period. During one week the rota showed that the registered manager was only on shift twice. Another rota for another week showed they were only on shift once. This meant that the registered manager was not available to carry out their role and responsibilities as they were carrying out their nursing role.

Despite people’s positive feedback on the cleanliness of the home there had been recent concerns relating to pest control. The home’s diary evidenced that a mouse had been seen in the kitchen on 10 December 2015. The registered manager had not taken steps to address these concerns until 29 December 2015 when the home called pest control. This was after mice had been seen in four people’s bedrooms, the dining room and the kitchen. We saw that there were traps laid down in the kitchen to deal with this issue. The registered manager had not addressed this issue in a timely manner.

The provider had systems and processes in place to audit and monitor the quality of the service. These audits were being carried out by the administrator who had not been in post for the previous two months prior to this inspection. Audits had not been carried out since this member of staff had stopped work. We spoke with the registered manager about what arrangements they had made to ensure that audits were carried out whilst this person was not available. They told us that they carried out the audits, but that they had not made a record of them. There was no evidence that these audits were being completed or any actions taken as a result of the findings.

The registered provider had put in place a new set of policies and procedures. These were kept in the nurses’ office where all staff had access to them. It was not apparent if the registered provider had read these policies and was not aware that some of them were not fit for purpose as they did not reflect practice within the home. It was the overall responsibility of the registered manager to carry out medicines audits. We noted that the registered nurse had been carrying these out over the last few months. We asked the registered manager if they had been over seeing these audits as per the provider’s policy. They told us that they had not and that they were not aware of their obligation to do this. The registered manager and provider did not have an overview of the policies and procedures they had put in place as the registered provider.

Is the service well-led?

The examples above demonstrate that the provider has failed to operate an effective quality assurance system and failed to maintain accurate records and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This was a breach of Regulation 17 (1) (2) (a) (b) of The Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager was able to tell us about their role and responsibilities towards the care and support to people in the home. They told us that they had overall responsibility for clinical issues in the home. Training and health and safety was their responsibility. They were responsible for the environment and to negotiate with contractors. They were aware of their reporting responsibilities to the Care Quality Commission about incidents such as safeguarding issues and had sent in notification to CQC as appropriate. However, during the inspection we found that DoLS

authorisations had been made by the local authority which had not been reported by the registered manager to the CQC once they had been granted.

This failure to notify the CQC was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The registered manager told us the visions and values of the service were to provide a safe, caring and clean environment for people and to respect people's wishes. There had been improvements to the environment of the home since the last inspection but there was evidence that not all people's wishes had been respected in the care that they had received. We saw that staff echoed these values in the way they spoke and cared for people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>How the regulation was not being met:</p> <p>The provider was failing to meet people's needs and preferences in relation to activities.</p> <p>Regulation 9 (1) (a) (b) (c).</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>How the regulation was not being met:</p> <p>The registered provider was not deploying enough staff to meet people's assessed needs.</p> <p>Regulations 18 (1) (2) (a)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints</p> <p>Receiving and acting on complaints</p> <p>The provider and registered manager</p> <p>Regulation 16 (1) (2)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p>

This section is primarily information for the provider

Action we have told the provider to take

The provider was failing to operate effective systems to assess, monitor and improve quality and safety and to mitigate risks relating to the health and safety of people.

Regulation 17 (1) (2) (a) (b)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

The provider had not established and operated effective recruitment procedures.

Regulation 19(2)(a)(3)(a)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The provider had failed to notify CQC of important incidents.