Tree Vale Limited

Tree Vale Limited Acorn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 9, 10 and 11 November 2016. Tree Vale Acorn House is a four storey care home situated in a residential area of Prenton, Wirral. The home provides accommodation and personal care for up to 33 older adults. The home primarily caters for adults who live with dementia. Accommodation consists of 33 single bedrooms. A passenger lift enables access to all floors for people with mobility problems. On the ground floor, there is a communal lounge and dining room for people to use. There is also an additional small lounge on the first floor.

There was a registered manager in post. 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.'

During this visit, we identified concerns with the safety and quality of the service. We found breaches in relation to Regulations 9, 10, 11, 12, 14, 16 and 17 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.

We looked at the care files belonging to five people and found their needs and risks were not properly assessed, planned for or managed. There was insufficient information in people's files on how to keep people safe and meet their needs in a way they preferred. Risk assessments were inadequate and did not provide staff with sufficient guidance on how to manage people's risks in order to keep them safe. People's health needs were not adequately described and records showed that they had not always been followed up with healthcare professionals. Dementia care planning was poor and staff had limited guidance on how to provide safe, appropriate person centred care.

We found people's capacity was assessed using the two stage test recommended by the Mental Capacity Act 2005 but people's assessments were generic and lacked evidence of their involvement in the assessment process. It was unclear how these assessments had been undertaken as there were no best interest decision records on file and no evidence that any least restrictive options had been explored. Some people had deprivation of liberty safeguarding (DoLS) in place but there was limited evidence as to how an assessment of their capacity in relation to this had been made.

Medicines were not always managed safely. Medicines received by the home were not always properly accounted for or stored at appropriate temperatures. This meant the management of medications was unsafe.

Systems in place to ensure people receive adequate nutrition and hydration were not robust. Risk assessments and care planning for people's dietary needs was poor and people's weights were not always monitored appropriately for any unintentional weight loss to be picked up and addressed. Professional

advice was not properly documented and healthcare appointments were not routinely followed up to ensure the person received the nutritional support they needed.

People's accidents and incidents were not monitored adequately to ensure action was taken to protect them from avoidable harm. A number of people had experienced multiple falls without a referral to the falls prevention team being made or assistive technology being put into place to help staff manage people's safety. This meant that the manager had failed to take any appropriate action to keep people safe. Poor moving and handling techniques were observed in use by staff at the home. This placed people at risk of injury. We spoke with the manager and senior carer about this and asked them to address it immediately.

Staff were observed to be kind, caring and compassionate in their interactions with people. There were lots of positive interactions between care staff and the people they looked after. Care staff spoke about the people they cared for with a genuine fondness and were able to tell us about some of their needs. Senior staff were a visible presence on the floor and supervised care staff well. The senior staff member we spoke with during our visit was observed to have good relationships with the people they cared for and their families. We saw that relatives and visitors were made welcome throughout the day and they told us they felt staff were approachable and kind.

People had access to a range of activities and the home employed an activities co-ordinator specifically for this purpose. During our visit, we saw that the activities co-ordinator played an active role and encouraged people to participate in the activities on offer. We found however that the planning of people's activities required improvement to ensure people knew what activities were on offer and that they met their preferences.

Safeguarding incidents were recorded and records showed were appropriately investigated and reported. Staff we spoke with knew about types of abuse and the action to take if they suspected abuse had occurred.

Staff recruitment was satisfactory and the majority of staff had received most of the training they needed to do their job role effectively. Some staff however did not receive their training in a timely manner. This meant they may have lacked some of the skills required for their job role. During our visit we saw that the number of staff on duty was sufficient but the majority of people were sat in the same room for the majority of the time and were not able to freely mobilise around the home. This made it easier for staff to manage people's requests for assistance.

We looked at the way the provider handled complaints. We found evidence that the provider's approach to people's complaints failed to ensure their concerns were responded to appropriately.

We also saw that the manager had failed to consistently address on-going concerns expressed by relatives in respect of people's personal belongings and that people's belonging were not always treated with respect. Some of the language used within the home to describe people, was inappropriate and disrespectful. This did not demonstrate that the management of the service cared about things that were important to people and their families.

The service was not well –led. Systems in place to monitor and manage risk to people's health, safety and welfare were limited and those that were in place were ineffective. There were no audits in place to check the management of people's care, accident and incidents, medication, health and safety, cleanliness and infection control. People did not have personal evacuation plans in place to ensure they were evacuated safely in the event of a fire and there were no effective systems in place to check that the home was a safe, clean and comfortable place to live.

During our inspection, the manager was not a visible presence and spent the majority of their day in the office. From our discussions about people's care and the service, they failed to demonstrate that they had an adequate understanding of people's needs and care and that they had sufficient knowledge of their managerial and legal responsibilities under the health and social care act. There was also no evidence that the provider audited the service, as a legal provider of regulated care to ensure that the service was safe, effective, caring, responsive and well-led.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
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Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's individual risks in the planning and delivery of care were not properly assessed or managed.

Inappropriate moving and handling techniques were used and people's accident and incidents were not responded to appropriately to protect them from harm.

Staff recruitment was satisfactory. Staffing levels were observed to be sufficient but most people were sat in the same room most of the day and unable to mobilise freely around the home.

Medication arrangements were unsafe. Medication was not stored safely and there were no systems in place to account for all medications.

Safeguarding incidents were identified and reported appropriately.

Is the service effective?

Requires Improvement

The service was not effective.

People's capacity was assessed using the Mental Capacity Act 2005 format, but assessments were generic and did not show that the MCA had been implemented as intended.

The majority of staff were trained. Some staff had not completed all of the training in a timely manner. Staff received appropriate support and supervision in their job role.

Systems in place to monitor and manage people's nutrition and hydration risks were not robust enough to ensure people's needs were met.

Is the service caring?

Requires Improvement

The service was not managed in a way that was consistently caring

Everyone we spoke with said the staff were good and treated them well.

Staff were observed to patient and compassionate with the people they supported

Concerns raised by relatives in respect of the treatment and loss of people's personal belongings had not been adequately addressed.

Inappropriate language was sometimes used to describe people's care.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed prior to admission to enable safe care to be delivered.

Care plans lacked information of people's needs and preferences to enable person centred care to be delivered.

Activities were provided but consideration needed to be given to people's preferred interests and hobbies.

The provider's complaint policy required improvement. The provider's response to a complaint was poor and did not demonstrate the provider listened to and responded to complaints appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of effective monitoring systems in place to check the service was safe and of a good standard.

The manager was not a visible presence in the home and the service was not managed in a way that ensured people's health, welfare and safety.

The provider failed to ensure the way the serviced was managed effectively and in a safe way.

Tree Vale Limited Acorn House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 9, 10 and 11 November 2016. The first day of the inspection was unannounced. The inspection was carried out by one adult social inspector. Prior to our visit, we received information of concern about the service from the Local Authority and we used this information to plan our visit. We also looked at any other information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with two people who lived at the home and four relatives. We also observed the provision of day to day care. We spoke with the registered manager, a senior carer, two care staff and the cook. We looked at a variety of records including five care records, recruitment records for three staff, staff training records, medication administration records and other documentation relating to the management of the service.

We looked at the communal areas that people shared in the home, did a tour of the home and visited some people's bedrooms.

Inadequate

Is the service safe?

Our findings

The majority of people who lived at the home lived with mental health conditions that meant they found it difficult to talk to us during our visit. We chatted to two people who lived at the home during our visit and asked four relatives about the care their loved one received. One person we spoke with was able to tell us that they felt safe at the home and that staff looked after them well. All four relatives told us they felt the person who lived at the home was safe there.

We looked at five people's care files. Some but not all of the risks in relation to people's care were assessed. There was a lack of sufficient detail in people's risk assessments on how the level of risk had been determined and how to prevent the risk from occurring. We found that people's risks were not always been managed in accordance with professional advice where it had been given by other health and social care professionals. This placed people at risk of inappropriate or unsafe care.

For example, one person's skin integrity risks had been discussed with staff and a shared plan of care put in to place by the district nurse team in order to prevent the person developing a pressure sore. A letter from the district nurse team indicated that staff had agreed to regularly reposition the person throughout the day and night due to their immobility. When we checked the person's risk assessment and care plan however, we found that none of the guidance given by the district nurse team had been included in this person's care plan for staff to follow. During our visit, we saw that the repositioning of this person during the day was minimal. We requested the person's repositioning records and saw that whilst repositioning during the night was recorded every two hours, there were no recorded entries to indicate the person was regularly supported to reposition during the day.

One person's accident and incident records showed that they had experienced 20 falls in the last eight months. One accident had resulted in the person being admitted to the accident and emergency department. We were concerned about this person's welfare and asked to see their care file.

We saw that this person's mobility was noted as unsteady. Their care plan advised that they were not to mobilise without staff support. Their falls risk assessment indicated they were at a very high risk of falls. It highlighted that the person was at an increased risk of a fall from bed and at night, due to their tendency to wander. The risk assessment stated that in order to manage this person's very high falls risk, they should reside in a room that could be frequently observed, referred to the falls prevention team and referred for assistive technology to enable staff to monitor their whereabouts so that they could be aware of the risk of a fall. We found that this risk management advice had not been followed. This meant the person had not been protected from avoidable harm.

We checked a sample of other accident and incident records and the action taken by the manager and found similar inadequacies in the way people's accident and incidents had been responded to. For example, two other people had also experienced multiple falls in a short period of time but no appropriate action had been taken to refer them to the falls prevention team or assistive technology services in order to protect them from further harm.

We found that accident and incident records were brief and did not detail the immediate action taken at the time the accident or incident occurred. After an accident or incident, people's falls and mobility risk assessments were not updated to reflect any increased risks and did not document any additional risk management measures to protect the person from further harm.

We found that the support provided by staff in respect of people's mobility was not always safe. We observed four incidences during our visit where inappropriate moving and handling techniques were used by staff to support people with mobility issues. These techniques placed people at significant risk of an accident or injury. We spoke with the manager and senior carer about this. They acknowledged that the techniques we observed were inappropriate. We asked the manager to address this immediately.

When we checked people's care files, we found no evidence that each person had a personal emergency evacuation plans (PEEPS) in place. PEEPS provide emergency service personnel with information about a person's needs and risks during an emergency situation such as a fire. This information assists emergency service personnel to quickly identify those most at risk and the best method by which to secure their safe evacuation. We asked the manager about this. They told us they were unaware a personal emergency evacuation plan was required.

These incidences were a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured the risks to people's health, safety and welfare were appropriately assessed and managed.

We looked at how the provider monitored the risk of Legionella in the home's water system. The provider's Legionella risk assessment was brief and did not show that the risks in relation to Legionella had been properly considered. The water checks in place to monitor and manage the risk were also inadequate. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. The provider failed in this duty of care.

We looked at the arrangements in place to ensure that the premises in which people lived, was safe and suitable for use. We saw that the kitchen was awarded a five star food hygiene rating from Environmental Health in April 2016. This meant food hygiene standards were rated as "Very good". The home's electrical and gas installations, moving and handling equipment and fire alarm system were all regularly inspected by external contractors who were competent to do so. We saw that the last fire alarm inspection and the last fire visit undertaken by Merseyside Fire Authority had identified some longer term improvements with regards to the home's fire safety provision. We asked the manager about these. They told us the provider had a plan in place to address these in due course.

We saw that various parts of the home had been refurbished. There was new carpet in various areas and most people had new and matching furniture in their bedrooms. On the first day of our visit, however we found that the cleanliness of the ground floor and other parts of the home required improvement. The laminate flooring in communal areas was dirty and staff had not picked up pieces of food that people had dropped on the floor during breakfast. The carpet by one person's bedroom was dusty. A shower chair in the ground floor bathroom was stained and one person's clothing was discarded on the floor by the toilet. The sink in the laundry room and the shower tray in the upstairs bathroom were dirty. We spoke with the manager about this. We asked to see the home's cleaning schedules. These were provided but they were difficult to understand. Each staff member had their own individual cleaning schedule but there was no evidence that an overall cleaning programme was in place. There was also no evidence the cleanliness of

the environment was monitored in a coherent way by the manager.

We asked to see the manager's infection control or environmental audits that showed that the manager monitored the home's environment for cleanliness and health and safety issues. The manager told us that no audits were undertaken. They told us they had a visit from the NHS Infection Control team and as a result of this visit, they had completed an action plan of improvements. We looked at the infection control audit completed by the NHS Infection control team and saw that the home's last audit was in August 2016. We saw that the home had an overall score of 86% for the control and prevention of infection. A score of 86% indicated the manager needed to take action to improve the cleanliness and risk of infection. Particular attention need to be given to the laundry and general environment whose cleanliness by the NHS team had been rated 'an organisational priority'. We found the action taken by the manager in relation to this audit and to manage the ongoing standards of cleanliness at the home was poor.

This example were a breach of Regulation 12 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to have effective systems in place to assess, prevent, detect and control the spread of infection.

We found the storage of medication at the home to be unsafe. Medicines were stored in a locked medication trolley in a locked cupboard. On the first two days of the inspection the temperature in the medication cupboard exceeded safe temperature ranges. The majority of medication should be stored at temperatures no greater than 25 centigrade. On day one of the inspection, the temperature in the medication cupboard was 28 centigrade and on day two, 27 centigrade. This meant there was a risk that medication may not have been safe to use or may have lost its effectiveness. We spoke with the manager about this and on day three of the inspection, a fan had been placed in the medication cupboard to reduce storage temperatures. The manager told us that they planned to have ventilation work undertaken on the cupboard as a longer term measure.

We looked at the medication administration records (MAR) for five people who lived at the home. We found that medication administration records had been signed for appropriately as and when medication had been administered. A stock count of the medication in the medication trolley was correct for the people whose medication we looked at, with the exception of one person. This meant there was a risk that this person had not received their medication as prescribed.

We found it difficult to account for prescribe 'as and when required' medications (PRN) such as painkillers and prescribed creams. There were no PRN plans in place to advise staff, how, when and why to administer these medications. Staff had also not recorded the quantity of medicines brought forward from the previous month at the start of the new medication cycle or recorded the actual quantity of medication in stock when any new medication supplies were received from the pharmacy. This meant it was difficult to tell if the amount of medication in stock was correct and whether medicines had been safely and correctly administered to people.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all medicines were stored safely to protect people from risk or recorded appropriately when medicines entered the home.

Records showed that senior care staff were trained to administer medication. We observed a medication round and saw that medication was given in an appropriate and pleasant way.

We looked at three staff files. All the files we looked at, showed that the necessary checks to ensure that staff

employed were of good character and suitable to work with vulnerable people, had been undertaken. Staffing levels during our visit were observed to be sufficient. Senior care staff were a visible presence 'on the floor' and ensured staff were supervised in their day to day duties so that people's needs were met in a timely manner. We found however that the majority of people were taken to and sat for most of the day in the communal lounge. They were unable to mobilise freely about the home which made it easier for staff to respond to their needs.

We spoke with two staff members about protecting vulnerable people from potential abuse (safeguarding). Both staff members were able to tell us about different types of abuse and what action they should take if they suspect abuse had occurred. Staff training records showed that the majority of staff members had received safeguarding training on a regular basis.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with during our visit, felt staff understood the person's needs and cared for them well. During our visit, we spoke with two care staff about one of the people they cared for. They were able tell us generally about people's needs.

Relatives we spoke with had mixed opinions about the food and the support people received with their nutrition. Two relatives told us that the person got enough to eat and drink and that the person liked the food. One relative told us the food was "A bit hit and miss", another said that their relative had lost weight since they had come to live at the home and they needed encouragement to eat.

We saw that the daily menu was written on a noticeboard by the communal lounge for people to read. There were however no visual prompts such as picture menus to make choosing a meal easier, for people who lived with dementia. The menus provided a varied selection of meals and were planned in advance. Two options were available for lunch and the evening meal. Details of people's special dietary requirements were displayed in the kitchen and the catering staff we spoke with knew what these were. Snacks and drinks were available and offered to people who lived at the home at frequent intervals throughout the day. We saw that two people were supported to eat by a staff member in the communal lounge and that staff assisted people discreetly and did not rush them.

We found that the dining room were some people ate their meals was busy and crowded but we observed that people did not appear to be affected by this. Tables were set with a tablecloth but there were no napkins or condiments on the table for people to use. We saw that the plates used to serve people's meals were of a side plate size as opposed to dinner plate size. This made it difficult for people to keep their food on their plate. Portion sizes were small but we heard staff offering people additional portions of food. Staff served people in a pleasant manner but all of the staff serving food and assisting people to eat wore blue latex gloves which did not look very nice.

We observed one person struggling to use the cutlery that they had been given. They struggled to eat the food on their plate which was sausage roll, chips and beans. We saw that this person's care plan indicated they required staff support to cut up their food. We saw that this had not been done. We saw the person was unable to cut up the sausage roll or the chips on their plate to eat. The person struggled for ten minutes to eat their lunch before a staff member came over to assist them. The staff member then simply cut the sausage roll in half and handed half the sausage roll to the person and placed it in their hand. The person continued to struggle not only to hold the sausage roll but to bite and chew the food, which ended up a soggy mess. This was not very dignified. We intervened and asked the staff member to cut up the person's food properly so that they were able to eat their meal.

We looked at this person's care file. In their file, there was a letter dated August 2014 that indicated they had received a home visit from the community dietician (Speech and Language Therapy Team – SALT) in respect of their nutrition. There was no information in the person's file however about what this was for and what advice had been given. We spoke with the manager and the senior carer about this as we had concerns

about the person's ability to chew the food they were given. They were unable to tell us why the home visit had taken place or what the outcome was. This meant they did not know if the diet they were providing to this person was suitable for them. Following our discussion, the manager told us they would refer the person back to the SALT team.

In the five care files we looked at, we saw that there was brief information about people's nutritional needs and risks but staff had little guidance on how to support people's dietary needs. For example, one person lived with diabetes but there was minimal information in the person's nutritional risk assessment and care plan about how this condition was monitored and managed or the symptoms to spot in the event of ill-health. We asked the manager about this. They told us that the person's relative monitored the person's blood sugars to ensure they remained within safe levels. There were no records or evidence however to show that regular discussions with the person's relative took place with regards to this. When we asked the manager when the person's blood sugars had last been taken or what the results were, they were unable to tell us. This meant staff could not be sure that the person's diabetes was being managed effectively.

Systems in place to manage the risk of unintentional weight loss failed to be robust. People's weight was not monitored in anyway if they were unable to weight bear. In some instances some people's weight had been not been assessed for six months. We spoke with the manager and senior carer about this. They were unaware that a person's weight (body mass index- BMI) could be assessed using the person's arm circumference. This meant the weight of some people had not been monitored to ensure their nutritional needs were met.

Records relating to people whose weight had been monitored were also out of date. They contained information in respect of people who no longer lived at the home. Although no-one who lived at the home, looked malnourished, the lack of accurate weight management records made it difficult to get an overall picture of whether people's nutritional needs were being managed effectively.

These examples were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to ensure that people's nutritional and hydration needs were always met.

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

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 that a capacity assessment in relation to each person's ability to make decisions in a number of areas was completed prior to an application to deprive them of their liberty being made. People's capacity assessments however were a 'tick box' assessment of their ability to make decisions in a range of areas for example; accommodation, personal care, administration of medication, finances and eating and drinking. People's assessments failed to show what specific decision the person's capacity was being assessed for and how the conclusion that the person's capacity was impaired had been arrived at.

We saw that Deprivation of Liberty Safeguard applications had been made to, and approved by, the Local

Authority in relation people's care. The deprivation of liberty safeguards put into place prevented people from leaving the home of their own accord. There were however no specific capacity assessments in relation to the ability of each person to keep themselves safe outside of the home. There was no evidence that the person had been involved in their own assessment and no records to confirm that 'best interest' discussions had taken place with the person's family and other health and social work professionals involved in the person's care. There was also no explanation as to what alternative least restrictive options had been explored before a decision to deprive the person of their liberty had been taken.

Consent forms for the sharing of information, taking of photos and care plans were in place in some of the care files we looked at. For some of these people, their consent forms had been signed by a relative. The Mental Capacity Act 2005 (MCA) states relatives cannot be asked to sign consent forms when a person lacks capacity unless they have authority to make health and welfare decisions for the person under a Lasting Power of Attorney or a Court Appointed Deputy. People's care files contained no evidence that their relatives had this power.

During our visit, we found that the environment was difficult to navigate around due to the home being spread over different floors with key pad locks on corridors. Some of the bathrooms on the upper floors were locked as were some people's bedrooms. This meant that once people were taken to the communal lounge, they had no choice about returning to their room later in the day if they wanted to. This meant their liberty of movement within the building was restricted. Orientation was particularly hard as there was limited signage to help people find their way around the home.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's consent in relation to their care and treatment.

Throughout the inspection we heard staff seeking verbal consent from people prior to providing support. This ensured that people gave their consent to the care being offered before it was provided. Staff we spoke with demonstrated an understanding of mental capacity and how to promote people's choice in their day to day lives.

We looked at staff training records and saw that the majority of staff employed over 12 months had received adequate training to meet the needs of the people they cared for. Training for example was provided on moving and handling; health and safety, safeguarding, fire safety, first aid, food hygiene, infection control and dementia. Staff members were also able to work towards a recognised Level 2 or 3 qualification in health and social care. We found however some staff and some of the bank staff employed to work at the home on an 'as and when' required basis had not completed all of the provider's mandatory training programme.

For example, one permanent member of staff had not had moving and handling, health and safety, food hygiene, fire, safeguarding, infection control and dementia training, despite a refresh of this training being required in August 2016. Three bank staff had not received moving and handling, fire and dementia training and two had not received safeguarding and health and safety training. Two members of the housekeeping team had not completed food hygiene training since 2014 yet were responsible for preparing people's breakfasts. This meant there was a risk that these staff would not have the knowledge to provide effective care in these areas.

We spoke with the manager about the provider's training programme. They told us that training was planned in accordance with the provider's policy. They told us they were unable to organise a training

session for less than seven staff at any one time. This meant that at times, training for new members of staff or refresher training for existing members of staff was not completed in a timely manner. This placed people at risk of receiving inappropriate care.

We asked two staff members about the support they received from their line manager. Both staff told us they felt supported in their role and well trained. They said that they had regular supervision meetings with the senior carer to discuss their day to day role and an annual appraisal of their skills and abilities. We looked at five staff files and saw evidence to confirm this.

Requires Improvement

Is the service caring?

Our findings

We found the management of the service required improvement in order for the service to be consistently caring.

For example when we visited a sample of people's bedrooms, we saw that some people's wardrobes were untidy with unfolded clothes left on shelves or on the floor of their wardrobes. We saw that feedback received from relatives in August 2016, indicated that people's clothing often went missing. One relative had commented "We still have laundry issues where mum's clothes go missing, even though they are clearly marked. It is disappointing to see other residents wearing mum's clothes".

Another person's care file showed that the person's relative had also reported that they had concerns about the person's clothes going missing in June 2016 stating "Mum is often dressed in other people's clothes". The relative also reported that the person's clothes were sometimes rolled up on the bottom of the wardrobe and not hung up.

We spoke to the manager about the issues associated with people's clothing. They were unable to provide a satisfactory explanation. It was clear that following this feedback in June 2014 and August 2016, no adequate action had been taken to ensure people's belongings were safely laundered and returned, as these issues were brought to our attention again by relatives during our visit.

Two relatives we spoke with said some of their loved ones clothing, although clearly labelled had gone missing or that other people who lived at the home were seen to be wearing them. One relative said "Loads of clothes have gone missing" and another told us that some people "Don't have shoes". This did not demonstrate people's personal items were respected and cared for properly. It also did not demonstrate that people's dignity was promoted if they were found to be were wearing other people's clothes.

In a number of people's bedrooms we found continence products openly displayed for staff, relatives and other visitors to see which did not promote the person's right to privacy and dignity. On the dining room noticeboard, people eating habits and needs were documented for all to see with inappropriate language used to describe people. People were described as 'Eaters' if they were able to eat independently or 'Feeds' if they needed support to eat their meal. This type of language depersonalised people and did not show that staff were sensitive to people's feelings about being described openly in this way. On one of the toilet doors there was picture signage of a toilet. Someone had written the word 'poo' on the picture of the toilet and this had been allowed to remain. This was disrespectful.

We saw that one person during lunchtime struggled to physically eat their meal with the cutlery provided. We asked the manager and senior carer whether any adaptive cutlery had been considered in relation to this person's needs. They told us that they had not considered this. This meant that potential ways to support this person's continued independence and dignity at mealtimes had not been explored.

During our visit, we saw that people had access to a visiting hairdresser. People's hair however was styled in

the staff room which was a small room off the communal lounge. The door to the staff room was left open when people had their hair done. We saw that this room and the people in it, were clearly visible to other people who lived at the home, staff and visitors whilst they were having their hair done. This did not respect people's privacy and dignity.

We saw that care records contained photographs of each person in their file. Some of these photographs had been taken in circumstances that had not respected the person's right to privacy or dignity. For example, some of these photographs had been taken when the person looked to be asleep, which meant that the person may not have been unaware that they were being photographed.

None of the care files we looked at contained information about people's preferences in relation to their end of life care. Staff had also not received any training in how to support people who were at the end of their life. This meant that people could not be assured they would receive end of life care in line with their wishes.

These examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not always treated with dignity and respect at all times.

People we spoke with confirmed that staff were kind to them. Relatives we spoke with spoke positively about staff at the home. Their comments included "Staff are good"; "Staff here are excellent. The manager is very, very good"; "Staff are great" and "I'm very happy and appreciative of the care".

We found the atmosphere at the home to be warm and homely and we saw that visitors to the home were made welcome. During our visit, we observed many positive interactions between people who lived at the home and staff. Staff were kind and compassionate in their approach and people seemed relaxed and comfortable in their company. Staff chatted to people at eye level, used positive touch to reassure people and took an interest in what people had to say and listened.

Staff we spoke with had a basic understanding of people's needs and spoke about people affectionately. It was obvious from the staff we spoke with that they had a genuine fondness for the people they looked after.

Inadequate

Is the service responsive?

Our findings

The relatives we spoke with during our visit told us that staff were kind, approachable and kept them informed of any changes in the person's health and well-being when they visited. They told us they felt people were well looked after and that any decline in people's health was picked up quickly and the person's doctor called.

We looked at the care files belonging to five people. We saw that only one of the care files we looked at contained an assessment of the person's needs either before or on admission to the home. We asked the manager about this. They told us that sometimes they did not assess people's needs if the Local Authority provided information about the person when their admission to the home was agreed or if an emergency placement was arranged. This meant that an assessment of people's needs and preferences was not always carried out so that person centred care could be planned. This placed people at risk of receiving care that was inappropriate and which did not meet their needs or preferences.

We found that this lack of an appropriate assessment negatively affected the way each person's care was planned. People's care plans were written in an individualised way but they lacked sufficient detail about the person and their needs and risks. Some care plans lacked significant information about people's health needs and staff had little guidance on how to meet people's needs and care for them in a person centred way.

For example, one person had dressings on their legs but there was no information in the person's care file as to the reason why these dressings were in place. The person's care plan simply stated 'suffers with their lower legs'. Their risk assessment stated for 'staff to remain observant and aware of condition. Report change or take advice from district nurse' but failed to advise staff what they needed to be observant of and failed to provide guidance on what staff needed to check for so that any changes in the person's condition could be spotted and reported to the district nurse. This meant staff failed to have adequate person centred guidance on how to ensure this person's well-being was monitored and managed. We asked the manager and senior carer about this. They were unable to tell us what condition the person suffered from in respect of their lower legs. This meant this person's needs had not been properly assessed or investigated so that person centred care could be planned.

One person lived with a common skin condition on their legs which meant their skin sometimes became inflamed and painful. Despite this their care plan provided no explanation to staff on what this condition was, how it presented, what care the person required in respect of this condition and how to assess and manage the person's pain and discomfort. The person's care plan simply stated that the person's legs were creamed daily and for the GP to be contacted if they became red or swollen.

One person lived with severe anxiety that impacted on their day to day life. The person's care plan advised staff to give the person lots of reassurance and encouragement. There was no guidance given to staff on how best to communicate with the person when they became anxious or evidence that the person's anxiety levels had been monitored so that triggers or potential strategies for easing the person's anxiety could be

identified. We saw the person had an anxiety risk assessment in place but the majority of guidance given in relation to the person's anxiety related to the person's nutrition and skin integrity which was not relevant. There was little guidance on how to support this person in a person centred way.

Care plans and risk assessments had been dated as regularly reviewed but changes in people's health and well-being were not always documented or reviewed in relation to risk. For example, one person who care file we looked at, had experienced multiple falls but their care plan and falls risk assessment did not reflect this.
We saw that people's personal life histories had been completed by staff. Personal life histories enable the person to talk about their past and give staff, visitors and/or and other professionals an improved understanding of the person they are caring for. We saw little evidence however that this information had been incorporated into the person's care plan so that person centred care could be provided.

We saw that people had prompt access to their GP when they became unwell and there was some evidence in people's files of the involvement of other healthcare professional in relation to people's health needs. Information in respect of this however was sparse. For example, some people's care files contained letters that indicated they were required to attend or had attended a healthcare or medical appointment but there was no information in the person's file as to why the person had required this appointment, whether the appointment had been attended and its outcome. In some instances, we found no evidence that people's appointments had been followed up.

For example, one person's care file contained a final reminder letter from the diabetic eye screening clinic dated July 2016. There was no evidence in the person's care file that the person had attended this appointment or that the appointment had been followed up. Diabetic eye screening is an important part of people's diabetic care as it can help identify early signs of sight loss that can sometimes develop as a result of the person's diabetes. We asked the manager and senior carer about this. They were unaware of the letter in this person's file. They told us that the home had a regular optician who visited the home who could undertake this type of eye screening. They confirmed however that no referral to the optician for this screening to be done had been made. They told us they would do so without further delay. This did not demonstrate that the service was responsive and proactive in respect of people's needs.

These incidences were a breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure people were appropriately assessed and in receipt of person centred care that met their needs and preferences.

The home employed an activities co-ordinator. On each day of our visit, the activities co-ordinator took an active role in the communal area and encouraged people to participate in the activities on offer. During our visit, we observed a nail pampering session, a movie afternoon and a reminiscence session which enabled people to reflect back on previous times and share memories about past times. One relative we spoke with told us that the home had recently had an outside entertainer in and staff at the home had everyone up dancing and enjoying themselves. Another relative told us that they had just had a Halloween party at the home and that staff at the home always ensured people's birthdays were celebrated. This demonstrated that activities to occupy and interest people were thought of.

There was however no timetable of activities displayed on the noticeboard for people to refer to which meant that people had no information on what activities were planned. In addition, although there was information in people's life histories about the types of hobbies or interests people enjoyed before there was no evidence this type of information was used in any way to plan activities.

The manager told us that they had recently planned a trip to a local farm but that they had to postpone the trip on the day as it had been raining. We were unsure of the practicalities of this type of trip, as there were a significant number of people who lived at the home with mobility issues that would have found it difficult to participate.

The relatives we spoke with said that they had been given information on how to make a complaint when the person first came to live at the home. They told us they would discuss any concerns they had with the senior carer and felt confident their concerns would be responded to.

We saw that the provider's complaints procedure was displayed in the entrance area to the home. We found that the information provided required review. For example, there were no contact details for 'senior care team' or 'the manager' to whom people should direct their complaint in the first instance. No contact details were provided for the Local Government Ombudsman to whom people can refer their complaints onto if they remain dissatisfied and a reference to the NHS Complaint Department was misleading. The NHS Complaints Department only investigate complaints about services they commission via the NHS.

We saw that people were also directed to share their complaint with the Care Quality Commission. The Care Quality Commission welcomes and encourages people to share positive and negative experiences of care but has no legal powers to investigate individual complaints about service providers. This responsibility lies with the Local Authority funding the person's care.

We asked to see records of any complaints the manager or provider had received. The manager told us only one complaint had been received since our last inspection. We looked at this complaint and saw that the complaint had been referred to the Parliamentary and Health Service Ombudsman for investigation as the person making the complaint had been dissatisfied by the provider's response. We examined the report provided by the Local Parliamentary Ombudsman which clearly detailed the investigation they had undertaken into the person's complaint, the handling of the complaint by the provider and the outcome. We saw that the Local Parliamentary Ombudsman found the provider to have handled the complaint poorly and without empathy.

This was a breach of Regulation 16 as it showed the provider did not have an effective system in place to ensure complaints were listened to, handled with compassion and responded to appropriately.

Inadequate

Is the service well-led?

Our findings

We looked at the arrangements in place at the home to assess, monitor and mitigate risk to people's health, safety and welfare. We looked at the arrangements in place to ensure people experienced safe and appropriate care. We found the provider's arrangements to be inadequate.

People's care plan and risk management information did not ensure people received safe and appropriate care. Staff had no adequate information on people's needs and how to meet people's needs safely and in a person centred way. We asked the manager if they audited people's care plans to ensure they provided accurate, up to date and person centred information to staff. They told us no care plan audits were undertaken. This meant there were no systems in place to ensure that staff had sufficient information to provide good care.

We asked the manager if they audited the home's environment to ensure the home was a safe place to live. They told us they had recently done a check of the general environment for repairs and maintenance. We saw some evidence to confirm this but there was no evidence of regular checks and the manager acknowledged no regular environmental audits were undertaken.

We saw from the provider's NHS infection control audits, that the manager had improvements to make with regards to the cleanliness of the general environment, laundry and with infection control overall. We asked the manager if they undertook regular infection control audits to ensure the home was a clean and comfortable place for people to live. The manager told us no infection control audits were undertaken. This meant that despite having improvements to make, no effective system to monitor the cleanliness and general condition of the home had been implemented by the manager.

We asked the manager if they undertook accident and incident audits. They told us that the home's administrator had had responsibility for completing the paperwork associated with the audits but the administrator had now left the employment of the home. They told us that they had recently taken over responsibility for ensuring these audits were undertaken. We asked to see the audits completed. We saw that accident and incidents audits were not completed in a systematic way. There were no timescales by which accident and incident audit was done for example, monthly or quarterly. This made it difficult for multiple accident/incidents per person to be picked up and addressed. We saw that several people who lived at the home had experienced multiple falls and that no appropriate action had been taken by the manager to prevent further falls and avoidable harm. This demonstrated that the accident and incident audits in place were ineffective as they had not been used to identify and manage risks to people health, safety and welfare.

Accident and incident audits were also not analysed in any meaningful way so that trends or patterns in how, when and why people had an accident or incident could be identified. This meant the staff team did not learn from how accidents and incident occurred so that they could prevent them.

We asked the manager if any medication audits were completed to check that people's medication was

administered safely. They told us no medication audits were undertaken. This meant there was no effective system in place to ensure that medicines were managed appropriately. During our visit, we had concerns about the way medication was stored and accounted for.

We found that day to day care practices such as poor moving and handling, insufficient nutritional and weight monitoring, inappropriate use of language and the poor handling of people's belongings had not been identified or addressed by the manager. This showed a lack of managerial oversight and accountability.

We found that the manager was not a visible presence within the home and remained for the majority of the three days we visited in their office. The senior care team held the majority of the responsibility for people's care for example, care planning and the delivery of care. The manager did not appear to have any clear understanding of what care was being provided to each person. When questions were asked about people's care, the manager referred almost every question to the senior carer on duty. When the manager was asked about each of the audits referred to in this report, they told us they did not know they were required to do these audits. We found this lack of management oversight concerning.

We found no evidence that the provider audited the service in any meaningful way to ensure safe and appropriate care was provided to people or to check that the management of the home was safe, effective, caring, responsive, and well-led.

These examples demonstrated that the a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as no effective management system were in place to assess, monitor and manage risk to people's health, safety and welfare.

A satisfaction questionnaire had been given to people who lived at the home, their relatives and any visitors to the home in August 2016 to enable feedback on the service to be gained. Some relatives had raised issues with the laundry and missing belongings but on the whole, feedback was positive. We saw that a resident's meeting had been held in June 2016 and the service discussed with the people who lived in the home. There was no evidence that any further residents meetings had been held or were planned.

Throughout our visit, the staff team were pleasant and approachable. They were hospitable and polite and demonstrated a positive attitude. They worked well and were appropriately supervised by senior care staff.

At the end of our visit, we discussed our concerns with the manager and provider at the end of our visit. Both stated they were committed to ensuring that improvements were made to the service without further delay.

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 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no effective system in place to ensure complaints were received, listened to and responded to appropriately.