Care Quality Commission

Runwood Homes Limited

Ashwood - Ware

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection in Ashwood on 27 July 2016. We found that the service required improvement in some areas which included incidents not being sufficiently identified and reviewed to ensure people were kept safe and systems and processes for monitoring and reviewing the service were not consistently effective.

We undertook a focused inspection on 13 April 2017 in response to concerns raised to us about lack of staffing in Ashwood. During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to keeping people safe, medicines management, staffing and governance.
Ashwood is a purpose built care home and is registered to provide accommodation and personal care for up 64 older people some of whom are living with dementia. At the time of our inspection 60 people were living at Ashwood.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 were not supported by sufficient numbers of staff. As a result people experienced delays in having their needs met and the care and support they received was not always personalised.

People had their needs assessed and risks involved in their daily living were identified, however risk assessments were not reviewed every time people`s needs changed and there was not always sufficient guidance for staff in how to manage risks and keep people safe. People's medicines were not consistently managed safely. People`s records containing personal and confidential information were not always kept securely.

People`s lives were potentially at risk in the case of a fire. An independent fire safety audit carried out in January 2017 highlighted several faults around the home and the registered manager was unable to evidence that they have reported these to the provider or that the faults had been corrected.

The registered manager had been in post since December 2016. They had previously worked at the home however in a different role. People and staff told us they were unsettled by the management changes and also they found it difficult to adapt to the registered manager`s ways of working. Staff told us they didn't feel supported by the registered manager and they were not listened to.

Governance systems used by the registered manager to measure the quality of the care they delivered were not effective in highlighting areas where there was a need for improvement. Policies and procedures which had a direct impact on the safety of the environment and care were not reviewed by the registered manager

and they were still signed by the previous manager.

We found the provider to be in breach of regulation 12, 18 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The actions we told the provider to take are listed at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There was not enough staff to meet people`s needs promptly and deliver personalised care.

Risk involved in people`s daily living were not always documented and plans developed for staff to know how to mitigate risks.

People`s medicines were not always managed safely.

People`s safety in case of a fire was at risk because not all the faults identified by fire specialists in the home to prevent the spread of a fire had not been promptly resolved.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems and processes for monitoring and reviewing the service were not effective.

Important policies and procedures were not updated, reviewed and signed by the current registered manager.

People's care records were lacking in sufficient information to reliably inform staff about people`s current needs and risk management.

Staff felt that their voice was not heard and they were not supported by the management team.

People told us that the care they received had reduced in quality in the last couple of months due to the changes in staff and management in the home.

Care Quality Commission

Ashwood - Ware

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection at Ashwood- Ware on 13 April 2017. The inspection was carried out in response to some concerning information we received about the home. A team of two inspectors inspected the service against two of the five questions we ask about services: is the service safe and is the service well led.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We reviewed a copy of the action plan that was submitted to us after the inspection, and also sought feedback from professionals within the local authorities safeguarding and continuing healthcare teams.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with six people who lived at the home, six care staff, the deputy manager, the registered manager and the administrator. We looked at care records relating to five people together with other records relating to the overall management of the home.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and well looked after, however they felt there were not enough staff around. One person said, "I feel safe here of course I do, but it would be nice to have more staff about." Another person said, "They [staff] are so tired sometimes, I think they probably need a couple more staff especially first thing as it takes a long time to get up and have breakfast." A third person said, "I do feel safe here but I don't need staff as much as other people do. There use to be more staff here but they were cut back and now we need to wait [for care] more."

The views of the staff we spoke with varied between the day and night staff. When we spoke with a member of night staff they told us staffing was sufficient and that they had not used agency, having a stable and consistent night team. However, day staff felt there were not enough staff and at times poor sickness management and last minute non-attendance from some staff members added extra pressure for the staff on those shifts. One staff member said, "Sickness and last minute cancellations are killing the team, we end up short so then it takes longer to get the jobs done."

Staff told us they were working by prioritising people`s needs and not their preferences. One staff member said, "We try our best, but people are not getting any better and we need more staff. We help each other and go first to the ones [people] who are really in need so we keep them safe. People ring their bell and we have to say they need to wait." This was confirmed by people as well. One person told us, "They [staff] answer my bell and say that I need to wait because they cannot stay and help me because they are with somebody else. They do come back after a while." This meant that people experienced delays in having their needs met.

Our observations during the morning of the inspection confirmed that there were not enough staff to promptly meet people`s needs. Just before 8am we found one person calling out from the toilet. They had opened the door and were in an undignified state looking for a staff member to assist them. The administrator came along, who then assisted the person, however they had been calling out for five minutes with no response from the care staff in that bungalow, as staff were assisting other people. We observed at breakfast time that in order to save time staff laid out the breakfast table with people's cereals already poured out in bowls with sugar on top and milk in a jug next to it. People were heard to ask for a cooked breakfast but they were only given a choice of one cooked food, for example on the day of the inspection there was bacon on offer and the previous day there were tinned tomatoes. This meant that the care and support people received was not personalised because staff worked in a task orientated way due to the lack of staff.

When we looked at the rota we saw that the number of staff allocated on the rotas were not consistently available to meet people's needs. This was because the senior staff were allocated to provide care to people, however we observed this was not possible which was also confirmed to us by staff. For example, one senior staff member was on the rota, and expected to assist with personal care. However they were seen to be administering medicines when they arrived, and then spent the remainder of the morning in a review meeting with a person and professionals. We found that often there were only one or two floating staff members on the rota and not three as established by the provider. This meant that people who needed

assistance from two staff members had to wait longer until the floating staff member could help.

Because there were not enough staff to meet people`s needs in a timely way we found the provider to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments developed when risks to their well-being were identified. We found that staff were knowledgeable about people who were at risk of falls or at risk to develop pressure ulcers.

Risk assessments in people`s care plans identified what the risks were and gave staff guidance in how to mitigate these. However we found that risk assessments were not updated regularly and were not always reflective of people`s current needs. For example we saw staff assisting a person to transfer from their chair to a wheelchair. Staff used a handling belt which is a belt to assist people if they are unstable on their feet or they need a little support to stand up. However we saw this person not being able to sustain their weight at all. When staff used the belt they actually lifted the person up from under their arms. When we checked the care plan for this person we found that their moving and handling assessment carried out by staff evidenced that this person was `non weight-bearing` which meant that they were not able to sustain their weight. Despite this assessment the equipment listed for staff to use was a handling belt. This meant that staff were following the care plan, however this was incorrectly instructing staff and put the person at risk of harm. When we gave feedback to the registered manager, they agreed that the handling belt should not be used by staff to transfer the person and a new assessment was needed to ensure this person`s safety.

Staff completed food and fluid records for people who were at risk of malnutrition. We noted that there were gaps in these records where staff did not always record the amount consumed or total the amounts at the end of the day. For example, the previous weekend before the inspection was significantly warm, however, from one person's record we saw that they had consumed only 410 millilitres of fluid one day and 480ml the previous day. There was no target recorded on the monitoring charts although in the person`s care plan the GP in October 2016 indicated a minimum of 1000 millilitres as the recommended amount over 24 hours. The registered manager told us that since the GP`s recommendation in October 2016 this has changed and staff should calculate the required amount using a formula which took into account people`s weight. However this was not recorded in the care plans and the person we observed was not weighed by staff due to them being permanently in bed. The low fluid intake for this person was not identified by staff and they had not referred this to the registered manager or GP for review. This meant that this person could have been at risk of dehydration because staff had not followed current guidance on what amount this person should drink.

We found that people had no personal emergency evacuation plans (PEEPS) completed. The registered manager had an overview of all the people living in the home and what equipment they needed to use to mobilise, such as walking frames or wheelchairs. However the provider`s policy clearly asked for individual PEEPS for people where more information should have been provided to staff.

There was a fire safety audit carried out by a fire safety specialist on 18 January 2017. The audit highlighted several areas in the home where faults were identified. For example smoke seals were identified as missing from five doors; ten fire doors were found not to close fully when the alarm was set off. This meant that the faulty doors were less effective to contain a fire for the required time. The registered manager could not evidence on the day of the inspection that they reported these faults to the provider or that these had been rectified. In addition, the home had the emergency lighting tested on 12 January 2017 which also identified faults of lighting not turning on when electricity was switched off. Following the inspection the provider sent us evidence to confirm that these faults were corrected on 31 January 2017.

People had not always received their medicines safely. Not all the staff who administered medicines

adhered to best practice when they administered people`s medicines.

We found that medicine administration record (MAR) charts were not always signed when medicines were administered. For example on the day prior to our inspection staff had marked the MAR with a dot for a person, but not signed it when they gave the medicines. When we checked the carried forward stock against the remaining medicines we found that this medicine had been missed. We found the same omission with another medicine for the same person. There were discrepancies when we counted the medicines for two other people. When we finished with the MAR record and placed the folder in the bottom of the medicine trolley, in the presence of a staff member we found a small blue tablet. The staff member could not identify this, neither could we; however, this confirmed that the management of medicines was not safe or effective.

We also found when reviewing the MAR's that people who had medicines prescribed to them as and when required (PRN) did not have a detailed protocol in place. For example a person was prescribed pain relief on a PRN basis. The protocol in place did not describe to staff how to identify if a person was in pain to ensure they were able to effectively administer pain relief.

We found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks involved in people`s daily living were not sufficiently mitigated to keep people safe and people had not always received their medicines safely.

We looked at three staff recruitment files. For two staff, the original reference details listed in the application were not taken up through referencing, but a different reference not previously declared had been sought. These had not been verified to ensure they were valid and this meant that staff had significant unexplained gaps in their employment history. We saw however that staff had undergone their disclosure and barring service checks and provided evidence of their identity. The registered manager kept a copy of the interview record and where appropriate recorded relevant training along with verification. However, the provider could not be sure that staff were of sufficient good character because they did not fully check staff's employment history and verify reasons for leaving previous employment. The registered manager told us, "We have fed back to [Provider] that the company doing the referencing has problems with the way it does get the references, and that candidates are completing the forms with inappropriate referees using friends as references." This was an area in need of improvement.

Staff we spoke with were able to describe to us how to identify possible abuse, and were clear in how they would report this. Staff told us that they received regular updates for their safeguarding adults from abuse training and were also aware of external organisations they could report their concerns to. Information was available in the home for people, staff and visitors to refer to in relation to reporting any concerns.

Incidents and body maps were used when an incident of possible injury required reporting. Staff appropriately documented any issues relating to unexplained bruises or abrasions and gave these to the senior team for review. Body maps were descriptive and indicated the precise location the date and the time of the day staff observed these injuries.

Requires Improvement

Is the service well-led?

Our findings

There was a new registered manager in position at Ashwood- Ware. They had been in post since December 2016 after the previous registered manager left the service. People and staff told us the transition from one management style to another created tension and unsettled people and staff. One person told us, "You just don't know what is going on. The manager [previous registered manager] just left one day and [name of current registered manager] took over. This home used to be organised now it is disorganised. Staff are very unhappy and there are not enough of them." One staff member told us, "The new manager is having a go, but they have got a team that don't all want to pull in the same direction, so many think the job is just to pop in and out when they want and to be paid for it."

The registered manager told us they felt that some staff were not committed to their jobs and often let the team down by reporting last minute sickness which had a negative impact on the rest of the team and people. They told us they had to have a strong attitude and challenge staff who in their opinion failed to work within the provider`s expectation. They told us they held staff meetings where they challenged staff`s attitude and informed staff of the new rules they implemented and staff had a responsibility to follow these. For example there was a staff meeting held in March 2017 where two issues were discussed centred around cancelling shifts at the last moment, and the registered managers concerns regarding gossip in the home. The registered manager also used the meeting to inform staff they needed to accept changes to the rota.

Staff told us that they struggled to adapt to this new style of management. One staff member said, "We are never asked we are just told and we need to do what we are told. It makes us stressed and we are struggling." Another staff member said, "I think it was better before [the current registered manger], we were better supported and listened to."

Staff told us the management team were not listening or acting on their feedback. One staff member told us, "We reported so many times that we haven't got enough staff. They [management] don't listen. We are short almost every day." Another staff member said, "It is very hard. Some days we only have one floating staff member for the six bungalows it is impossible to get everyone up in time."

We looked at the last dependency assessment for people that was completed on 20 March 2017 and found that staffing had not changed despite four people moving to the home since the date of the assessment. We also looked at the rotas and found that for the two weeks prior to the inspection the home used less staffing hours than established as being required by the provider. The week before, the home was understaffed by 108 care hours. This meant that there was a possibility that the required care hours were not correctly calculated because more people moved in the home and there were staff shortages most days of the week.

When we asked the registered manager how they reviewed their staffing levels they could not explain to us, neither could the administrator nor the deputy manager. They told us that the care team manager role was included within the allocation to provide care for people in the mornings and this should have been the explanation for the uncovered care hours. However, we saw on the day of the inspection that the care team managers administered medicines, chased appointments, and one care team manager spent most of the

morning in a review with health professionals. Therefore we found that there were inadequate staffing levels in the home and the systems and processes to review and adjust staffing levels were not effectively used and understood by the management team.

We observed that records for people were not held securely. In two bungalows staff accessed people's records from an unlocked filing cabinet. One of these cabinets had no lock on it, so was accessible to people and visitors and increased the risk of inappropriate access to people's personal information.

People`s care plans were not regularly updated to contain current information about their needs. For example Mental Capacity Assessments seen were historic and had not been regularly reviewed, assessments carried out to establish risks levels for people developing pressure ulcers (Waterlow) and assessments to establish the risk of malnutrition for people (MUST) in many cases were last reviewed in October 2016. One person had their falls assessment completed in February 2017, this was after staff found them kneeling on the floor holding the armchair with a skin tear to their knee. The person subsequently had falls after, however the care plan had not been reviewed.

Care plans that were developed did not contain sufficient detail for staff to be able to support people. For example, for one person who suffered from type one diabetes was mentioned in their nutritional plan that their food was to be liquidised and adapted for their diabetic requirements. However, the care plan did not provide any information about signs and symptoms for staff to observe when the person could present with low or high blood sugars. This meant that there was a risk that staff were not knowledgeable enough to keep this person safe by proactively monitoring their diabetes and seeking professional advice in case it was needed.

Monthly audits were in place; these were in areas such as infection control, health and safety, medicines, care records and staffing. The registered manager completed a monthly self-audit. We looked at the one completed for March 2017 and found that the actions identified by the registered manager for that month were regarding keeping offices tidy and displaying the planned monthly activities. These were signed off as completed. However, the registered manager's self-audit did not address issues identified through this inspection, such as staffing levels, people`s care records not being updated, food and fluid records not being totalled or assessments not being correctly calculated. We also found that a recent fire inspection had highlighted several key areas for action that had not been addressed or reviewed by the registered manager. The fire evacuation policy and procedure still had the previous managers` signature and was not reviewed by the current registered manager.

A quality improvement plan had been developed and we were told by the registered manager that this was reviewed monthly by them and the regional manager. The last review of this document had been completed in March 2017. This reviewed areas such as the environment, medication, care records, infection control, training, development and safeguarding concerns, such as falls, incidents, injuries and pressure care. However, the quality improvement plan remained the same throughout several months. Each month the registered manager noted that they had achieved the area to be improved, however next month the same area was listed again. For example, in training the agreed action was for the registered manager to identify staff training needs and to motivate all staff to undertake e-learning. However there was no description of what the issues were and how the improvements would be monitored. This meant that the actions taken by the registered manager were not sufficiently robust to sustain the improvements.

When we looked at areas within the audit that related to the safety of people, we found that the review of falls from November 2016 up to March 2017 gave the same preventative measures for people. For example, one person's actions to mitigate the risk remained that they were not suitable to attend falls clinic due to

their behaviour and co-ordination. The registered manager explained that due to the location of falls at various places in the home they considered that the use of a sensor mat would not be beneficial. Although there were no recent falls recorded for this person the registered manager had not considered to use the sensor mat in this person`s bedroom where they were on their own to alert staff if this person needed help and prevent falls. This meant that the systems and reviews to improve the quality of care that people received at Ashwood – Ware were not sufficiently robust to ensure people experienced consistently good quality care.

Due to the failings of maintaining efficient systems and processes, secure and contemporaneous records, and failing to actively listen to people and staff regarding the management of the home and the risks this presented on the health and safety of people living in Ashwood – Ware we found the provider in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks involved in people`s daily living were sufficiently mitigated and regularly reviewed.  The provider failed to ensure that best practice was followed by staff when administering people`s medicines and that these procedures were safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that the systems and processes in place were effectively used to improve the quality and the safety of the care people received. The provider failed to ensure that records containing personal information for the people living in the home were securely stored. The provider failed to ensure that people`s care plans contained up to date information and accurately reflected their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure they had enough staff allocated and deployed in the home to

meet people`s needs in a timely way.