Aston Grange Care Limited

Aston Grange Care Home

Inspection report

484-512 Forest Road
London
Tel: 020 8509 1509
Website: www.astongrangecarehome.co.uk

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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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Aston Grange care Home provides accommodation and care for up to 45 people, most of whom were living with dementia. At the time of our visit there were 44 people using the service. The home does not provide nursing care.

The inspection took place on 13 and 14 August 2015 and was unannounced. The home did not have a registered manager in post on the day of our inspection. A registered manager is a person who has been 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 and associated Regulations about how the service is run. There was manager in the home who was not registered with CQC.

At our last inspection in September 2013, we found the home was meeting the legal requirements that were inspected.

People and their relatives told us the staff were caring and hardworking. People's privacy and dignity was not always maintained. We saw one person wished to use the

Summary of findings

bathroom and had to wait for a hoist to be available. There were not always enough staff to provide person centred care to people and not enough equipment to provide the support needed.

Not all staff had undertaken training regarding safeguarding adults. The staff we spoke with had a good understanding of abuse and how to raise any concerns.

Risk assessments were not robust and did not include measures to identify and control risks to individuals and the service.

Care plans did not contain enough information to provide good care. The review mechanisms were not effective and plans were not updated to reflect changes in people's needs.

People had sufficient food and drink to keep them healthy, however feedback about the food was mixed and mealtimes were not a positive experience for people. Some people had to wait before they were served their food. Food, fluid and weight monitoring systems were not effective which means the home could not identify people at risk of malnutrition.

Systems to monitor the quality of the service were in place but were not being used. The leadership of the organisation was not effectively monitoring quality or driving improvement.

People's healthcare needs were being met. People were registered with a local GP who visited the home weekly. Visits from other healthcare professionals also took place.

We looked at the medicines policy and saw that staff gave medicines to people in accordance with this policy. There were gaps in medicines administration records and times when people had not received medicines because they had been out of stock. This meant that medicines were not managed safely.

Staff recruitment procedures were safe and the employment files contained all the relevant checks to help ensure only appropriate people were employed to work in the home.

People were engaged in activities in the home, both in shared areas and in their own rooms.

There was a complaints procedure available to people in the home and records showed complaints made had been appropriately investigated and responded to.

The service operated in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We found seven breaches of regulations. You can see what action we have asked the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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?

Inadequate

The service was not safe.

Risks were not always identified and managed appropriately. There were not enough staff or equipment to meet people's needs which meant that people had to wait for care to be provided.

Aspects of the premises were unsafe. The fire evacuation plan was not safe and areas of the home were unclean and unhygienic.

The provider did not ensure that medicines were recorded and ordered safely.

The provider's recruitment practices ensured the staff were suitable to work in the home.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had access to training, supervision and staff meetings to help them carry out their roles effectively. However, some training had not been effective.

The systems for ensuring that people had enough to eat and drink were not effective in ensuring that nutrition and hydration needs were met.

The provider had followed procedures under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that care was only provided with people's valid consent or within legal requirements if they were not able to consent.

Is the service caring?

Requires improvement

The service was not consistently caring.

Although people and their relatives felt they were treated with kindness, we observed instances when people's privacy and dignity was compromised.

People's needs and preferences were not captured in care plans.

People's rooms were highly personalised and relatives were able to visit freely.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Assessments were not always kept up to date to ensure people's care plans reflected their changing needs.

A variety of activities were provided for people both in shared areas of the home and for people in their rooms.

There was a complaints policy and people were aware of how to complain.

Summary of findings

Is the service well-led?

The service was not well led. Staff did not feel the provider listened to their concerns about staffing levels.

The provider conducted quality audits but they were not thorough enough to be effective and had failed to identify the failings we found.

Records were not completed in a clear way.

Inadequate

Aston Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 13 and 14 August 2015 and was unannounced. It was carried out by three inspectors, a nursing care specialist, estates and facilities specialist and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we already held about the service. We reviewed previous inspection reports for this service. We also reviewed notifications, safeguarding alerts and monitoring information from the local authority. We spoke with local authority commissioning and adult safeguarding teams.

During the inspection we spoke with 11 people who used the service and three relatives. We spoke with 15 staff including the nominated individual, the manager who was not yet registered with CQC, chef, catering assistant, maintenance person, one senior care assistant and ten care assistants. We looked at eight people's care files, ten staff files, staff duty rotas, a range of audits, complaints folder, various meeting minutes, incidents and accidents log, safeguarding folder, activities timetable, food menus and policies and procedures for the home and other documents relevant to the management of the service such as audits. We observed care and support in communal areas and also looked at some people's bedrooms and bathrooms, with their permission. We 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.

Inadequate

Is the service safe?

Our findings

Staff told us they had training on safeguarding and were able to describe the different types of abuse and what actions they would take if they suspected abuse. Records showed that some staff had not received this training in over a year and some had never received it out of a staff team of 52. The service had a robust policy for safeguarding adults, but it did not contain the details of the local safeguarding team. We viewed the incident reports for June and July 2015 and saw one incident of one person hitting another had not been raised as a safeguarding alert. This means the service is not protecting people from harm.

The above issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were not robust or personalised. People had a medication risk assessment in which the control measures stated were the medication administration process, this was not a sufficient risk management strategy. Medication risk assessments were identical in seven of the files and did not contain individualised information about the risks of the specific medicines people were taking. This meant that there was no individual information available to staff about what the risks to people were and how to manage them. This created a risk that adverse effects of medicines were not recognised and side effects went unmanaged. Moving and handling risk assessments were brief and contained only basic information such as the need for two carers and a hoist. For example, one stated "I need two staff as I need to be hoisted." The service had a risk assessment policy which stated that risk assessments should be conducted for all residents in relation to their nutritional status, falls, skin health, and daily living environment. These were not found in care files. This meant that people were at risk of receiving unsafe support as the information required to support them safely was not available to staff.

One risk assessment stated that "When [person] tries to get away from the building, he has to be restrained by staff." However, we could find no associated risk assessments, capacity assessments or meeting minutes where this was confirmed. When this was discussed with staff and the manager this related to an incident when this person first moved to the service and staff had to intervene physically to protect his safety. One member of staff described how one person who was at risk of falls had this risk managed through the use of the belt on their wheelchair. However, there was no documented capacity assessment, best interests meeting or risk assessment associated with this practice. The manager and nominated individual told us they do not use physical intervention or restraint. The conflicting information between the policy, care plans and practice means that risks were not being managed so that people were protected and their freedom was supported and respected.

We observed medicines administration and saw that good practice guidance was met. The medicines folder was easy to follow, and included individual medicines administration records (MAR) for each person. For one person there was an inconsistency between their summary page and MAR sheet regarding drug allergies which increased the risk of error for safe medicines administration.

We reviewed the MAR charts and found both explained and unexplained gaps in signatures in three files viewed. In some cases, medicines had not been administered because of a lack of stock. We saw records showing what the home had done about this but one person had been without pain relief on seven occasions and without diabetic medicine once which put their health at risk. We also saw that one person refused medicine frequently but there were no contingency plans or guidelines for staff to help them identify if this person was becoming unwell as a result. This put this person's health at risk.

The storage of creams and liquid medicines was not safe and well recorded. We saw that creams, liquid medicines and drops were not dated when they were opened and some were being stored in shared bathrooms. Liquid medicines and creams should have the date they are opened recorded as they can lose effectiveness over time. Likewise prescribed creams should not be stored in shared bathrooms as they are a prescribed medicine. When stored in shared areas there is a risk that they may be used inappropriately.

People were put at risk of unsafe premises. The shared bathrooms were unsafe to use as they were crowded with equipment and missing toilet seats. The hot water in one shower was measured at 48 degrees. Department of Health guidance states the maximum allowed is 41 (Health Technical Memorandum (HTM) 04-01). There were no measures in place to address this issue and this put people

at risk of being scolded by hot water. Staff told us water temperatures were tested monthly, but the records could not be found on the day of inspection. The window restrictors were easily over-ridden which contradicts Health and Safety Executive guidance which states that where there is a risk people could fall from windows they should be restricted to 100mm. The home had recently updated their fire safety and evacuation plan. However, the measures in place were not sufficient and people would not have been able to escape safely in the event of a fire. The emergency lighting was not bright enough and four lights were not working. The evacuation route was not suitable, the path was uneven, full of weeds and had animal excrement, and this meant there was a risk of falls during an evacuation. The gate was locked with an electronic keypad which is linked to the fire alarm system and opens immediately when the alarm is activated.

We saw poor practice in terms of infection control. One domestic staff member was wearing three pairs of gloves because they did not have gloves in their size. The home had a domestic cupboard where cleaning materials were stored. This was heavily congested with domestic materials such as mops and buckets and did not identify the products in use and safe handling instructions. Care homes are required to have a policy and risk assessment relating to Control of Substances Hazardous to Health (COSHH) such as cleaning products. There was no COSHH certificate, list of products in use or risk assessment in place. This meant there were no measures in place to prevent these substances causing harm. The home had two sluice rooms one of which was unlocked throughout our visit and the lock was not working. Sluice rooms are dirty utilities, used for soiled material and should be kept locked to ensure that people do not become exposed to soiled material. The rooms were dirty and did not meet the required standard for compliance with the Health Care Associated Infections (HCAI) code of practice. There was plaster damage to the walls in both rooms and an unidentified spillage. There was a strong smell of urine in one of these rooms which spread into the hallway outside affecting the atmosphere of the home. We observed the kitchen and bathrooms were dirty and saw a domestic worker was not adhering to good infection control practice in terms of using colour coded mops and buckets to clean floors. There was no nominated infection control lead in the home. The member of staff working in the laundry was unable to tell us the emergency procedures if the washing machine stopped working or the standard temperature in which to wash soiled items. The staff member stated the temperature should be 40 degrees when the temperature required by the Department of Health Infection Control Guidance is 65. This means the home was not protecting people from the risk of infections and was not following Department of Health infection control guidance for care homes

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where medicines were prescribed to be given 'only when needed' or where they were to be used only under specific circumstances, individual required protocols were in place. The protocols gave administration guidance to inform staff about when these medicines should and should not be given. This ensured people were given their medicines when they needed them and in a way that was both safe and consistent. The storage of controlled drugs and medicines was in line with good practice, with suitable locked cabinets and supporting records. Staff who administered medicines told us they underwent training. They were able to describe the correct processes for administration and what to do if they discovered an error. One staff member told us, "If we find a missed medicine we report it to the seniors who call the GP." Records showed that staff had training in medicines administration.

The accidents and incidents log showed that on seven occasions in June 2015 and six occasions in July 2015 various residents had been "found on the floor." Though the initial response had been appropriate these were not linked to individuals so it was not possible to track if this was happening repeatedly to certain individuals. There was no evidence that these incidents were being reviewed by management and no follow up actions were recorded. This means there is a risk that patterns of incidents are missed and lessons are not learned.

A visiting health professional told us they were concerned that people were left in lounges without supervision when other people were receiving personal care. We observed that dependency levels in the service meant that when people were receiving care others were left without support. We entered a room to see a resident who appeared unsteady on their feet walking around the room. The manager told us they recognised the problems with the current staffing levels and agreed there were not enough staff. The nominated individual told us they would

Inadequate

Is the service safe?

be re-assessing staffing levels. Staffing levels were not safe as people with a high risk of falls were left unsupervised when others received support. Staff rotas showed that staffing levels were as described, with two or three care assistants on each floor with a senior care assistant across the whole service during the day and one care assistant per floor with a senior care assistant across the whole service at night.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staff files showed that recruitment processes were safe. Application forms were completed, identification checks made, criminal record checks completed before starting work and references received. Some staff were only able to provide character references, or one employer reference. In these cases the service had conducted a work based assessment as part of their induction to confirm they were suitable for the role. This was an effective measure to ensure staff are suitable to work with people.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us they received good support to meet their health needs. One person said, "The home was good when I had to have my cataracts done, they [care staff] were very attentive." Other people told us they saw health professionals such as the doctor, dentist and optician regularly. Health professionals visited daily and they confirmed they had an effective working relationship with the home. The GP visited each week and people were supported with hospital appointments where necessary. Records of health appointments showed when people attended the appointment and the advice received from medical professionals. Staff told us this was cascaded to care staff through handover meetings. However, information from the handover book was not linked to care files and was not used to update care plans and risk assessments. This introduced a risk that staff would not provide the most up to date health support to people as it was not contained in individual files. Staff confirmed that it was difficult to catch up if they had been on holiday as handover only provided information on that day rather than the previous weeks.

People gave us mixed feedback about the food. Some people told us the food was good and they had choice, One person said, "Mediocre to say the best." One person and a relative said they would like to have more vegetables and salads. The service had a four weekly rotating food menu which was changed every three months. People who used the service were asked on the day what they wanted from the menu and a list was completed on each floor which then was sent to the kitchen. We found the staff were familiar with people's dietary needs. We saw drinks were offered throughout the day and during the mealtimes to people. Records showed people had requested an alternative meal not on the food menu.

The chef told us they knew who had special dietary needs, such as diabetes or soft food because they were informed when people arrived at the home. However, the information about specialist diets was not easily available for all the kitchen staff. The chef did not work every day and while they were able to tell us in detail about people's dietary needs, other kitchen staff were unable to tell us this information. This means there is a risk that people receive food that does not meet their dietary requirements when the chef is not working.

We saw two files where people had fluid recording sheets in place but these were not always completed and did not lead to changes in support. One person had a fluid recording sheet which indicated they should be drinking 1500ml per day but over 3 days in August only 60-120ml was recorded. There were inconsistencies in how fluid intake was recorded. For example, for one person it stated "half a cup of tea" and on other days the amount in millilitres. This showed that people were not being supported to have their food and drink needs met.

The arrangements for the monitoring and meeting the hydration and nutritional needs of people were not robust.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. The manager knew how to make an application for consideration to deprive a person of their liberty. Discussions took place with the manager regarding how the recent judgement by the Supreme Court impacted on the provider's responsibility to ensure DoLS authorisations were in place for people who used the service. We saw applications were documented which included details of risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the manager was able to explain the process she followed in ensuring best interest meetings were held involving relatives and other health and social care professionals. In preparing for this inspection we looked at the information we already held about the service. We found the provider had sent us statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS).

Staff told us that they sought consent from people when they had capacity, but were less clear about how they supported people whose ability to make and express their choices was limited. One staff member told us they didn't know how to seek consent and said, "that's a difficult question." When this was explored staff told us they used their knowledge of people's past to ensure they were given choices that they would like, for example regarding

Requires improvement

Is the service effective?

clothing choices. Needs assessments and care plans were not signed by the people they were about. This means there is a risk that the home is not routinely seeking consent from people in line with legal requirements.

The staff we spoke with told us they had received an induction and we saw a comprehensive induction checklist which included information about the service and residents that staff needed to know. However, staff informed us, and management confirmed they were aware, some recently recruited staff had not completed this induction. We saw a new member of staff supporting someone to eat who had not completed any training in this area. Staff told us they received regular training. One staff member said, "We are trained and every year there are checks on our skills so that we are up to date." We looked at the training records of the service which showed staff had received training in areas including moving and handling, food hygiene, health and safety, infection control, medicines and fire safety. The manager told us the effectiveness of training was evaluated through supervisions. Given the infection control issues identified at the service it was clear the training received by domestic staff in infection control had not been effective. Staff told us they had been receiving supervision since the new manager had been in post and they found these useful and could "raise any concerns" through these meetings. The staff files viewed showed that supervisions were used to discuss residents' needs, work performance, team work and training. The provider did not provide appraisals, the manager told us they planned to introduce these and they were scheduled for the end of 2015.

Requires improvement

Is the service caring?

Our findings

People and their relatives gave us mixed feedback about how caring they found the home. One person said, "Staff are marvellous. They always come in and see me." A relative said, "I've seen carers go through the worst possible day so patiently and good humoured. I am humbled by them." However, other people said it was, "Ok but not wonderful." Another resident indicated that some staff were "OK", but others were not. Relatives said they felt welcomed in the service and could visit when they wanted, and staff told us they found this really helpful. A staff member said, "It helps us know more about the resident and their likes and dislikes. It is also very interesting to witness various relationships." Staff we spoke with told us that they prioritised getting to know residents and their relationships with them. One staff member said, "I feel passionate about this work, I see the residents like my mum and dad. I love to listen to their stories." Another staff member said, "I'm one for the residents' rights. This is their home and they have every right to ask, and if they don't ask you have to provide anyway."

We saw some people's support being delivered in a patient and caring manner. However, we also saw some task focussed support, particularly around mealtimes. Staff told us they found they did not have time to develop relationships with people and the only time they could talk to people was during personal care.

The care plans contained very limited information about people's life histories and preferences. For example, we saw they contained information about whether or not people had married and what their job had been. There was not enough detail for staff to use to start a conversation with people. Relatives told us they had been to review meetings but the only signatures on all the care plans we viewed belonged to staff. Feedback in the relatives' survey included that some people did not feel they had been involved in reviewing care. There was no evidence that people were being supported to express their views and be involved in making decisions about their care. There was no information about people's cultural needs or sexuality. There was a section in the template for this to be completed but in the files we viewed it was either blank or unrelated to culture or sexuality. For example, one person's cultural needs were described as "skin intact" and another's sexuality said "Likes to wear a shirt and jeans and a hat indoors." This showed the service lacked information about and understanding of cultural and sexuality needs of the people living there. This meant people were at risk of receiving support that was inappropriate and not person centred.

Staff told us that they promoted people's dignity when supporting them with personal care by ensuring doors were shut and that people were covered. However, we saw one person being supported in a communal bathroom with the door open. We also saw that people who required the use of a hoist to use the bathroom had their dignity compromised. This was because there were not enough hoists and they had to wait for a hoist to come from a different floor before they could be supported. We saw one person who was clearly in need of the toilet and was at risk of soiling themselves because the hoist was unavailable. They had to wait for over five minutes for the hoist to be located. This was not dignified for the person.

The above issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service responsive?

Our findings

A relative told us, "I am always informed if there is a change in my mother's behaviour or appetite." Healthcare professionals also told us that the service was quick to report any concerns to them and responded to advice given.

We found care plans were not detailed enough to provide staff with the information they needed to provide personalised care. One plan contained good information about how the person liked to be supported in the morning with a good level of detail about their personal care and breakfast routine. Despite this good information, the plan also stated that "[person] should have a shower twice a week (on Wednesday and Sunday) but sometimes staff are busy, so they need to politely explain to [person] that [they] can have it another day and handover to other staff." Another plan stated, "I need support with all my care needs." but provided no more detail about how care should be delivered.

We observed people over a lunch period. We saw that this was not done in a personalised or sensitive way. During our observation we saw one staff member who was supporting someone to eat did not talk to that person over the lunch period, and left them without explanation five times during half an hour. They were going to support other people or complete other tasks. On another floor we saw that people who required support to eat and drink had to wait for staff to be available. They had not started eating their meals 30 minutes after other people, and 15 minutes after people who could eat independently had finished their food. People were sitting at their chairs wearing aprons and sleeping while other people were supported to eat. This was no personalised or caring support.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We saw activities were on offer and were recorded photographically by the activities coordinator. We saw a range of activities were offered including bingo, modelling clay, group and individual art sessions and singing. There were books for people to pick up and read at reception and we saw the activities coordinator making sure a person had received a book they had been interested in reading. People also told us that they went to the pub, shops and local clubs. Recently the home had been visited by an organisation with exotic animals such as snakes, which people told us they had enjoyed. The home has an old fashioned sweet shop on the middle floor which is not used. This is potentially an excellent resource for dementia friendly activities and has the potential to be used for activities in the home. We saw that people's bedrooms had been personalised and had people's photographs on the doors to help with orientation.

The service had a complaints procedure and information on how to make a complaint was in display in the reception area. The complaints procedure contained details of who people could complain to if they were not satisfied with the response from the service and timescales for complaints to be dealt with. We saw the records of complaints and found the service was listening to people's and their relatives' problems and concerns. We found the complaints were investigated appropriately and the service aimed to provide resolution for every complaint in a timely manner.

There were other ways in which people could inform the provider of their views about the service. Residents and separate relatives meetings were held. The last recorded relatives meeting was held in March 2015. Topics included refurbishment of the premises, activities, food menu, relatives' surveys and the quality of the care. We were told by the manager that a relatives meeting had been held since however the minutes had not been typed up. Two relatives we spoke with were aware of relatives meetings although they were unable to attend. One relative said, "I have received a couple of letters about relative meetings." The last recorded residents meeting was held September 2014. We asked senior staff why there had not been a meeting since September 2014, however no reason was given. The last resident meeting included topics on food menu, complaints and staffing.

Inadequate

Is the service well-led?

Our findings

A member of staff told us, "We don't feel cared for but we're expected to care." This reflected the feedback from staff that they felt under a lot of pressure and did not feel they had the resources needed to provide good quality support to the people who lived there. Another member of staff told us, "We're all very stressed." They continued, "We're running on the goodwill of staff. They're loyal to the home and the people here, not the company." Despite this, staff were positive about the newly appointed manager. Three staff said "I feel for [manager]." They recognised that there was a willingness to make changes and that the new manager had responded positively when they had raised their concerns about practices in the home. Staff told us they were aware that the manager needed additional support to make the changes they wanted regarding staffing and equipment and they were not confident that the provider would supply these.

People and their relatives told us they could talk to the manager and staff told us that they could bring any concerns to their attention. We saw relatives and staff talking easily to the manager during the course of our inspection.

Staff told us, and records confirmed, staff meetings took place. Staff told us they could speak freely in these meetings to raise concerns. However, there were no plans in place to address issues and actions taken so far, such as reformatting the care plans, had not been effective.

The provider conducted quality assurance visits and these recorded that staff were raising issues relating to the rota and were described as "disgruntled" but no actions were recorded. These visits recorded that maintenance, audits and care files were checked. It was recorded in consecutive months that audits had not been completed but there was no action plan to ensure this happened. We found no completed audits on our inspection. It was also recorded that care plans were satisfactory when our review demonstrated they were not.

Staff told us, and records confirmed, monthly reviews were conducted by the service. However, these did not relate to people's care plans and did not lead to changes in plans. They were of a poor quality and some reports were the same from month to month. For example, one person's reports from March and April were identical and the May report was the same as February and included that "as we are still in winter." One person's monthly summary identified issues with other people using their equipment but it was not clear how this information was shared and the issue was then raised again in a later summary. The quality assurance had not identified the poor quality of monthly reviews or that there were multiple incidents of people being found on the floor at night. There was no systematic analysis of care delivered and therefore it was not possible for the provider to be assured that they were delivering high quality care. The local authority has supported the provider to improve its quality assurance monitoring and the current template had a clear actions template.

We saw that the home recorded people's weight monthly and kept body maps where necessary. These were located centrally which meant that as stand-alone documents they were not being used to identify issues that might require further support, for example weight loss or repeated skin issues. There were no systems to link appointment records and information about people's physical health to their care plan and risk assessments. As incidents were stored centrally and not included in monthly reviews there were no mechanisms to identify patterns or the need to amend risk assessments. As there was no recorded audit of this information management was not able to ensure that people were receiving the correct support. There was no guidance for staff to use to analyse and use the information collected.

The supplying pharmacist conducted monthly audits and sampled medicines from different floors on each visit. The audit for June 2015 was seen and it was noted that gaps on MAR charts had improved, and that 'as required' (PRN) medications needed to be better managed to prevent them running out. There was no linked plan to ensure that these observations were acted upon. Checks on MAR charts were conducted weekly where MAR charts were selected and checked against set criteria. The records showed these were conducted and noted some of the issues we found, however, there was no associated plan to address the issues.

The home had subscribed to a policy service. This meant that policies were robust and detailed. However, they were not available to staff as they could only be accessed via the manager's computer. The policies did were not specific to the service and contained no local information. For

Inadequate

Is the service well-led?

example, the local safeguarding team contact details were not in the safeguarding policy and there was no named lead for infection control or health and safety. The policies were not being implemented in the home. For example, the policy for skin integrity stated that each resident would have a skin integrity risk assessment and the diabetes policy stated all people with a diagnosis of diabetes would have an individual nutrition and diabetes plan. In the files we saw none of these measures was in place. This means the home is not implementing good practice guidance from its policies.

The provider was asked to supply inspectors with a number of documents relating to the safety of premises and equipment. A number of key documents could not be supplied or were inadequate. For example, the infection control and health and safety policies did not identify a lead person. This meant there was no person taking responsibility for the monitoring and improvement of infection control and health and safety issues. Care homes are required to test and maintain their equipment in order to ensure it is safe to use. The following tests and certificates could not be located on the day of our inspection: lift testing certificates, portable appliance testing to ensure electrical goods are safe to use, certification of testing and commissioning for bed rails in accordance to the provisions and use of work regulations 1998, environmental health officer certification for the main kitchen, Lifting operations and Lifting Regulations (LOLER) 1998 testing and commissioning certifications. LOLER testing ensures the equipment used to life people is safe for both people being lifted and staff using the equipment. That these documents could not be found means that systems in place to ensure safe management of the premises, equipment, infection control and health and safety were not effective.

The issues with quality assurance and leadership are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Service users were not receiving person centred care because care plans did not reflect their preferences and care was not designed with a view to achieving preferences. Regulation 9(1)(c)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not treated with dignity as they had to wait to receive care. Regulation 10(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment because not all staff had training in safeguarding adults. Regulation 13(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Service users were at risk of not having their nutritional needs met because monitoring of food and drink intake was inadequate. Regulation 14(4)(a)(d)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not receiving safe care because risks to their health and safety had not been properly assessed, the premises was not safe for their intended purpose, the equipment was not sufficient, medicines were not managed safely and the risks of, prevention, detecting and control of infections was not well managed. Regulation 12 (2)(b)(d)(g)(h)

The enforcement action we took:
We issued a warning notice to the provider to be complaint with this regulation by 30 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems to monitor, evaluate and improve the quality of care were not sufficient. Regulation 17 (1)(2)(a)(b)(d)(ii)

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 30 October 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff to meet people's needs. Regulation 18(1)

The enforcement action we took:
We issued a warning notice to the provider to be compliant with this regulation by 30 September 2015.