Ashfield Specialist Care Limited

# Ashfield Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

Ashfield Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is registered to provide care and support to older people with dementia or mental health needs. On the day of inspection there were 36 people living there.

The inspection visit took place on the 4 October 2018. It was unannounced and was planned as a focused inspection, in response to concerns that had been raised with us since the last comprehensive inspection in July 2018. After that inspection we received concerns in relation to staffing levels, unsafe care, poor management and the impact on people using the service. As a result, we undertook a focused inspection to look at safe and well led. This report only covers our findings in relation to those areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ashfield Nursing Home on our website at www.cqc.org.uk.

At this inspection we found continued breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; plus, a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because we were concerned the service was not meeting some legal requirements. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Since the last inspection, there had not been sufficient improvement in the overall governance of the service. The management of medicines, infection control and staffing had continued to deteriorate and the service is now rated inadequate and means the service is 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 enough improvement is not made within this timeframe and 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 and 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.

On the day of inspection there was no registered manager in post. The previous registered manager left in August 2018 and de-registered with the CQC. However, the new manager, who was present throughout the inspection, was in the process of completing their registration with us. They were also supported by the provider and a registered manager from another service managed by the provider. 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.

There was a whistleblowing policy in place and staff knew how to escalate concerns to external organisations if they were concerned about people's care. The manager had notified us of two safeguarding incidents. However, we found more incidents where people had been at risk of harm that had not been notified to us and it was not clear whether information had always been shared with the local authority or safeguarding team.

Risk assessments were in place for many aspects of care, but they were not always robust and were not always updated promptly after an incident or change of circumstances. Daily records were not completed contemporaneously. This meant staff did not always have access to up-to-date information and we were not assured that people received their planned care.

The manager told us that people needed 10 staff to meet their dependency needs. We checked the rota for October and found there was not 10 staff on any day of the month. We also found that some staff included in the rota were not able to provide personal care as they were new and had not completed their induction or provided all necessary pre-employment checks. This meant there was not enough trained and experienced staff on duty to meet the identified needs of people.

Processes regarding storage, administration and recording of medicines were inadequate. Medicines were not stored safely. One medicines room was not fit for purpose as it was too small and unhygienic. There were no hand washing facilities in the room and we found records and unused medicines discarded on the floor.

Medicines were not always administered safely. We found medicine errors in all three medicine records we looked at. These errors included – missed medicines, not administering the dosage prescribed and unsafe practice regarding covert medicines (hidden in food or drinks). Audits of medicines were not completed.

There was a history of non-compliance in respect of infection control and we found cleaning was still not a good standard. We found unclean communal toilets and offensive odours in people's rooms and communal

corridors. The provider had not made the improvements required from the last inspection to make surfaces more hygienic and easier to clean; apart from one shower room which had been renovated.

The service was not well led. The provider had not provided the management and resources necessary to make the improvements identified at the last inspection; and had been rated 'requires improvement' in well led, at the last three inspections. There was no registered manager in post. However, the new manager had been in post for nine weeks and was in the process of completing the registration process with CQC.

Quality assurance was inadequate and had not identified where improvements were required. For example, they had not identified medicine errors and inadequate cleaning. Many areas for improvement identified at the last inspection were incomplete which indicated they had not been well managed.

Information regarding risks to people was not always shared with relevant organisations and we did not always receive notification of incidents where people were at risk of harm.

Contingency plans in place to ensure the service was adequately staffed during this period of staff change, were not effective. The service was frequently understaffed in respect of the providers dependency tool, which concluded they required 10 staff on duty to meet people's needs. This impacted on the providers ability to implement their improvement plan as they were now focused on staff recruitment and induction.

Healthcare practitioners who worked in partnership with the staff at Ashfield Nursing Home, said staff responded positively to feedback and followed guidance given to them about how to meet people's individual care needs. They said staff did a good job caring for people with complex needs and in difficult circumstances.

## 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.

Risk assessments were not always robust and not always updated promptly after an event or change of circumstances. Records were not completed contemporaneously. Staff did not always have up-to-date information to care for people safely.

There was not enough trained and experienced staff on duty to meet the identified needs of people.

Medicines were not managed safely. Processes regarding storage, administration and recording of medicines were inadequate.

The environment was difficult to keep clean. Infection control and cleaning was not a good standard.

Staff understood their responsibilities to report concerns about people's safety to relevant people.

### Is the service well-led?

**Inadequate**

The service was not well led.

There was no registered manager in post.

Management by the provider was not effective at bringing about the improvements identified at the last inspection. Resources had not been prioritised to make the necessary changes to ensure people received high quality care in a safe environment.

A high turnover of staff in recent weeks meant there were less experienced and knowledgeable staff available to care for people. The rota did not accurately reflect the dependency needs of people.

Quality assurance systems were inadequate. There was a history non-compliance regarding quality assurance at this service and this was still evident at this inspection. The provider had not identified some of the areas we identified as requiring improvement; and where they had, there was insufficient

improvement since the last inspection.

# Ashfield Nursing Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned as a focused inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, in respect of safe and well led; and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 October 2018 at Ashfield House Nursing Home. The inspection was unannounced.

The inspection team consisted of one inspector, one inspection manager and a specialist professional advisor. The advisor was a nurse with experience of managing staff and caring for older people with dementia.

The inspection was prompted by concerns that had been raised with us by staff and members of the public since the last inspection in July 2018. The information shared with CQC indicated potential concerns about the management of the service, poor staffing levels and impact on people. This inspection examined those risks.

Before the inspection visit we reviewed any information the provider had sent us. This included the provider information return (PIR) and notifications. A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred.

During the inspection we spoke with six people who used the service or their relatives. We spoke with the manager, owner and seven staff which included staff who worked in care, housekeeping, kitchens and maintenance. We also spoke to four visiting healthcare practitioners. We reviewed six care records and looked at needs assessments, risk assessments, contact with other healthcare services and daily care records. We looked at management records which included staff recruitment records, policies, development plans, quality assurance audits and evidence of training. After the inspection visit we asked the manager to send us further information regarding minutes of meetings with people, families and staff; cleaning

schedules; action plans and minutes of meetings with the provider. We also asked for further information regarding an incident we had been advised of. All this information was sent within the requested timescale.

Inadequate

# Is the service safe?

## Our findings

At the last inspection medicines were not always administered safely and the provider was found in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found further concerns regarding safe administration of medicines and the provider remained in breach of Regulation 12.

For example, one person had been prescribed 2 x 5mg of medicine to be given once a day. However, the medicine administration records (MAR) indicated they had been administered 1 x 5mg once a day on four occasions. This meant they had not received the prescribed dose. They were also prescribed a second medicine to be given 1 or 2 tablets, twice a day, but the dose administered was not identified on the MAR sheet. This meant staff did not know how much had been given and were not able to assess the most appropriate dose. Another person's MAR was signed as 'given' on Tuesday before the inspection, yet it was still in the blister pack in the medicines trolley on Thursday. They had been given medicines on Wednesday and Thursday morning but staff had not noticed that it was missed the previous day.

Staff could not account for the errors in administration and could not explain why the missed medicine had not been identified. When we discussed this with the manager they confirmed that a medication audit should happen and was imminent. They were not clear how frequently medicines were audited within the service and said it had not been done since they had started in August. There was no pharmacy audit available for us to view.

Pain relief was not always administered in line with recommended practice. Some people required medicine occasionally for pain relief or relief of temporary conditions. However, information was not always available to guide staff on how, when and how much medicine was required. There was no pain assessment tool used to determine when pain relief may be beneficial. This meant staff did not always have easy access to information that enabled them to safely administer medicine to people. Administration of such medicines was not always accurately recorded on the MAR and staff did not always ask if this was required when administering other medicines. This meant people were at risk of receiving too much or too little pain relief.

People's medicines were not always administered safely or in line with recommended practice. Some people who had been assessed as not having capacity to make decisions for themselves, often refused essential medicine, so they were given their medicines covertly (hidden in food or drinks). Appropriate approvals were in place to make sure this was in their best interests. However, guidance from the pharmacy about how to safely administer medicines covertly were not always available. Staff could not assure us that the most effective method was used to ensure people received their medicines safely.

We found records relating to the administration of topical creams were not contemporaneous and not completed by the staff who applied the creams. We were not assured that the records were accurate and people received the creams as they were prescribed. This meant people were at risk of inconsistent care of their skin conditions.

At the last inspection in July, we found the facilities for storing medicines was inadequate. At this inspection we found some improvements had been made to the upstairs medicine room. However, the downstairs medicine cupboard was still not fit for purpose. There was no hand washing facility in this room and apart from the medicine trolley there was no other storage or preparation area in this room. The trolley was too high for staff to use the top as a preparation surface and with no other shelves or surfaces in the room, unused medicines and files were discarded on the floor, which was not clean or sterile. Due to the lack of additional storage in this room staff told us they had to go upstairs for some people's medicines that were not stored in the medicine trolley.

We found a large order of medicines received four days prior to the inspection were still unpacked and in their plastic delivery boxes in a storage room. The storage room was not clinically clean or temperature controlled which meant it was not the ideal environment to store medicines. Topical creams were stored in people's rooms rather than with other medicines which meant they were not always stored at optimum temperature. They were easily accessible to people entering the rooms which could mean they were not hygienic.

Medicines were not managed safely and we could not be assured that people always received their medicines as prescribed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not enough suitably qualified, experienced and knowledgeable staff available to meet people's complex needs. Before the inspection, we had received reports of low staffing levels and people being neglected as there was not enough staff to care for them safely. During the inspection, we checked rotas and spoke to the manager, owner and staff about staffing levels within the home. We found the rotas supported the concerns we had received regarding staffing levels and we found examples of how this impacted on people during the day of inspection.

Although initially we thought there appeared to be enough staff, on closer examination we found there were fewer experienced staff available who could provide the level of care people needed. This meant people's needs were not always met in a timely manner.

There was a significant impact of this at lunchtime when there was not enough staff available to meet people's identified behaviour needs whilst they were waiting for the lunch to be served. People became anxious and began banging items on tables, shouting and swearing at each other; others became restless and started standing up and walking around. In such a confined space this behaviour increased people's anxiety, as well as increasing the risk of falls and trips as people bumped into furniture and each other.

There was not enough staff available to keep people occupied and stimulated. People were not engaged in personalised activities that interested them. This resulted in some people becoming bored, restless and anxious. We saw some people shouting out for long periods with little response from staff, another was banging a cup on the table; when we asked about this, one staff member said, "Oh they just do that when they get bored." One person told us they liked to go out into the garden but as there was a step they needed assistance from staff. They said, "I ask staff to help me outside but they are too busy, I wait for ages so I don't bother asking now." I asked staff how they engaged people with activities that interested them, they said they tried to follow on from what the activity workers used to do but as they had no training, some staff found it difficult and resorted to using the TV to occupy people. The lack of meaningful activity resulted in people becoming bored and anxious, this impacted on their behaviour which could put themselves and others at risk of emotional distress.

The provider confirmed they had made changes to the staffing levels to suit current dependency needs of people and said they currently needed 10 care staff during the day to care for people. We saw evidence of dependency assessments in people's care records. These records identified if people needed one or two care staff, to assist them with their personal care.

The manager told us there were 10 care staff working on the day of inspection – four upstairs and six downstairs. However, when we spoke to staff we found that three people were new staff who were not yet working unsupervised with people. The new staff spent their time in the dining room or communal lounges, providing general assistance to people. This meant there were only seven care staff available to provide personal care to people. We checked the 4-week rota and found only 9 people on the rota for the day of inspection. For the week of the inspection and for the remaining three weeks of the rota there was not one day when 10 staff were rota'd for the full day shift. Care staff numbers ranged from 6 – 9.5. New staff were also included in the rota for some of those days, when they were not yet able to care for people. This meant the manager was not planning the rota to meet the identified dependency needs of people and there was not enough staff on duty to respond to people in a timely manner.

The manager told us they were actively recruiting new staff but in the interim current staff were happy to do extra hours to make sure people were cared for. Staff we spoke with confirmed that there were times when staffing levels were low, especially during holidays and sickness. One person said, "Before (the new manager started) there were more staff on duty, so if someone was off sick it didn't make too much difference, as there was enough of us to look after people". They also said, "Yes, there's not enough of us sometimes, it's mainly when staff are on holiday and someone phones in sick or gives their notice on the day, as it's difficult to cover shifts at short notice. I don't mind staying longer and have done loads of extra shifts recently, but it doesn't suit everyone". A second staff member confirmed some staff did over time to cover shifts, but they were not able to due to family commitments. Staff confirmed there were occasions when there were fewer staff than was planned for and this impacted on how quickly they could attend to people's requests for support.

There was not enough suitably qualified, experienced and knowledgeable staff available to meet people's complex needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – staffing. You can see what action we told the provider to take at the back of the full version of the report.

Risk assessments were not always accurate or updated promptly after incidents or changes in people's care needs. For example, a staff member told us they decided to move the commode next to one person's bed at night, to reduce the risk of them falling, when they used the commode independently. However, this had not been recorded in the risk assessment, the care plan or on handover sheets. This meant other staff were not aware of the changes to this person's care which could potentially put them at risk of falling in the night. Although the manager said staff knew about this, we were not assured staff had up-to-date information about how to provide safe care to this person.

Records were not always maintained to provide us with the assurance that peoples pressure care was being considered. For example, we viewed a selection of daily records relating to the care of people's skin integrity in the afternoon and found they were not completed contemporaneously. For example, one person's 'health safety and wellbeing' checks had been signed as completed every hour from 8.00am to 2.00pm; yet their 'repositioning chart' had not been completed since 8.00am. Another person's records, showed they had been repositioned and had personal care at 4.00pm yet it was not yet 4.00pm when we read the records. A third person's records had not been updated by 5.05 yet they should have been repositioned by 4.00pm. Poor record keeping meant we could not be assured that people received the care they needed to manage

known risks and maintain their general health.

At the previous inspection in July we identified improvements were required to create and maintain a clean and hygienic environment throughout the home. At this inspection we found some improvements had been made to a shower room which had been refurbished, and there was a redecoration plan in place. However, there had been insufficient improvement to overall cleaning and hygiene and people continued to be at risk of infection. Although we saw cleaning taking place during the inspection, it was ineffective at cleaning the poorly maintained surfaces and environment that contributed to poor infection control.

We found communal toilets were unclean and had not been checked by staff; three bedrooms we checked were odorous, table surfaces in dining areas were not always clean, taps and plugs had not been descaled or replaced, one person was brought to the dining room in a wheelchair that had stains and spills on the back of the seat. There were not enough chairs available for people to sit at the dining tables in either of the two dining rooms, staff brought in plastic chairs for people, but these were unclean and not suitable for a dining room. One staff member brought in a footstool so they could sit next to a person and support them to eat. This was too low to support the person comfortably and unhygienic; it was not suitable furniture for a dining room. There was little overall improvement in the cleanliness of the home; and the changes needed to the environment which would reduce the spread of infection and improve hygiene had not been made.

Lessons had not been learnt from our last inspection and the same areas of concern were still evident in management of medicines and infection control. The significant changes in staff had impacted on people's safety and the quality of care; and this had not been identified or addressed by the manager or the provider. The manager showed us examples of audits they had developed to monitor the quality of care, in response to the improvements identified at the last inspection. However, these had either not yet been started or had been in place for such a short time they could not evidence improvements.

Prior to the inspection we had received concerns from staff and members of the public about how a change in management and reduced staffing levels had impacted on the safety of people living at the home. This demonstrated that staff were aware of their responsibilities to report concerns if they felt they had not been addressed satisfactorily by the managers.

We had concerns regarding safe recruitment of new staff and staff caring for people without the necessary pre-employment checks in place. However, we checked staff recruitment records and found pre-employment checks were completed for most staff. Where the provider was still waiting for some information to be returned, risk assessments were in place to enable new staff to start work in a 'shadowing' capacity until their checks were completed. The manager assured us staff did not provide personal care, or care for people on their own, until all the necessary checks had been completed. We found no evidence to support the initial concerns.

Inadequate

# Is the service well-led?

## Our findings

At the previous two inspections the provider was found in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in respect of poor governance and ineffective quality assurance of the service. At this inspection we found there had been no significant improvements and the provider remained in breach of Regulation 17.

The service has been rated 'requires improvement' in 'effective' at three consecutive CQC inspections since March 2016. 'Safe' and 'well led' also required improvement at the last two inspections in June 2017 and July 2018. This inspection focussed on 'safe' and 'well led' and we found there had been no significant improvement in either area, since the last inspection. This demonstrated a continued lack of overall governance and quality assurance which has impacted on the quality of care people receive. The service is now rated inadequate overall and is now in special measures.

There was no registered manager in post on the day of inspection, although a new manager had recently been appointed. Staffing, medicines and infection control remained a concern and the evidence available did not reassure us this would change very soon.

Action plans produced after previous inspections had focused on 'quick fixes' and had not led to a culture of continuous improvement. Lessons had not been learnt from repeated mistakes and any changes had been short-lived and ineffective. The provider had not taken responsibility to develop a fully resourced and sustainable plan to improve the service. Consequently, the manager and the staff were always 'fire-fighting' and responding to issues rather than working pro-actively to prevent them occurring in the first place. For example, there had been no impact assessment of reducing staffing levels at a time when significant improvements were required; as identified in both a CQC inspection and an Infection, Prevention and Control Audit, in July 2018.

We spoke to the provider who agreed that improvements were required and explained their plans for the service which had started with the recruitment of a new manager. Although we saw the new manager's induction plan along with the refurbishment plan, we felt there was not enough evidence to demonstrate continuous improvement or learning from previous inspections. The impact of 14 staff leaving the service had hindered the providers plans for improvements; as they were now focused on recruitment and training of new staff. This placed additional responsibilities and workload on existing staff which was not sustainable.

The manager did not always share relevant information with other agencies. For example, the manager had notified the CQC of two safeguarding incidents; however, we found other incidents where they had not. For example, one person had been sent to hospital in an ambulance without any care staff supporting them, they then had to wait for their relative to join them at hospital. This person had dementia which meant they were confused and distressed by the time their relative had arrived. Although this incident had been investigated and recorded by the manager with appropriate recommendations for the future, they had not notified the CQC. Another incident regarding unsafe administration of covert medicines had been reported

to the local authority but not CQC. The provider had not ensured information was shared appropriately with all relevant services, to keep people safe.

We found the provider had not learnt when things had not gone well. They had not ensured effective governance of the service and had not monitored the overall performance and risk management of the service. The provider admitted there had been 'issues' since before the previous manager had left, yet they had not ensured the service was safely and effectively managed in the absence of a registered manager. For example, they had not conducted any 'staff leaving interviews' to find their reasons for leaving; or to assess why so many staff had left in such a short time period. There was no evidence to suggest they had reconsidered their decision to reduce staff levels following feedback from staff and in light of all the improvements required. There had also been no impact assessment to ensure people received safe and effective care following the changes to staffing.

Staff were aware and were concerned, that the new manager had been recruited and started work before all pre-employment checks had been completed. The provider assured us they had completed a risk assessment to ensure the manager was suitable for the role and was adequately supervised until their registration with CQC was completed. They also said risk assessments were in place for all new staff who were on shift before all the necessary checks were completed; and they did not provide personal care or one-to-one care during this period. However, this meant staffing numbers and the rota did not accurately meet people's dependency needs at the time of inspection. This put people at risk of unsafe or ineffective care.

The manager said nursing staff supported care staff where they could. However, with one nurse and one nursing assistant on duty to provide nursing care and medicines to 36 people, staff told us they had little time to support care staff. There were not enough skilled and knowledgeable staff available to meet people's identified needs. Staff were task focused, had little time to meet people's emotional needs and the provider had not identified this as a potential risk to people. This further demonstrated a lack of oversight and governance of the service; and a lack of understanding of the emotional and wellbeing needs of people with complex health conditions.

The quality assurance systems in place were not effective. When we spoke about medicine errors found during the inspection the manager said, "I need to do a full medication audit." Owing to a lack of robust monitoring and audits, the provider had not identified the issues associated with poor management of medicines; and had not taken the action required to address them. This left people at risk of unsafe administration of medicines. The provider had also not kept to the timescales in their plan to replace all taps and plugs that were showing signs of lime scale corrosion, which had been identified at previous inspections. The infection prevention and control audit conducted by the CCG in July 2018 stated, "this left people exposed to the risk of contact with legionella bacteria growth from lime scale impurities entering the water".

The governance of the service was inadequate. Internal quality assurance processes were not effective at identifying where improvements were needed and the provider had not responded constructively to improvements identified by external audits and previous inspections. There was no evidence of reflective practice and the providers response to previously identified improvements has not achieved a better quality of care. The provider did not have an overarching action plan in place to address the areas of concern we had identified at this and previous inspections.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – governance. You can see what action we told the provider to take at the back of the full

version of the report.

There was no clear vision for the service and staff did not feel included in decisions about how it was developed. Staff had been unsettled by all the changes since the last inspection and were taking time to adjust. Before the inspection we received complaints and concerns regarding the management of the service and the impact of changes on people who needed care. Staff told us they had tried to discuss this with the manager but they had been dismissive of their concerns. Some staff had complained of bullying and gave examples of unsafe care and practice. We found no evidence to support claims of bullying during our inspection. However, we have continued to receive concerns and complaints regarding the management of the service since the inspection, and we are processing these in line with our methodology.

There were conflicting comments about the culture and inclusiveness of the management team and the impact this had on people and staff. The changes to the rota had not necessarily been introduced or implemented in an open and inclusive way and this had a significant impact on staff, many of whom had left the service. This had a further impact on the providers ability to complete improvements the service required; as they were now focused on recruitment and training of new staff. This meant the vision and plan for improvement was not viable or sustainable until they had a full and trained staff team.

Staff confirmed they worked extra shifts and long hours and said it was necessary to make sure people were safe and cared for, until new staff were appointed. Staff we spoke with during the inspection were positive about the manager and said they all wanted the best for the people they cared for.

Staff did not always feel engaged or empowered by the management team and felt decisions were imposed on them without adequate discussion or explanation. For example, we noticed that all staff wore gloves during lunchtime, when we asked about this, one staff member said, "Oh that's another new rule, that started about three weeks ago, no idea why." There was no evidence that people, families or staff had been involved or consulted about the changes to staffing numbers and rotas. Staff told us they were informed of changes to staffing levels and rotas in a meeting; and records we saw confirmed this. Prior to the inspection some staff told us they had left because changes had been imposed on them, without consultation; which they believed impacted on people's safety and the quality of care people received. They said they had tried to discuss this with the manager but they had been dismissive of their concerns.

The manager confirmed that some changes had been made, but said they were done with the intention of improving the quality of care and addressing the improvements identified at the last inspection. They said they had held a meeting with staff and explained this to them, but said some staff did not agree and decided to leave. They told us 14 staff had left since they started in August. Staff did not always feel engaged or consulted about developments within the service, many felt increasingly isolated and felt their views were not valued or respected.

Roles, responsibilities and accountability of staff was not clear. On the day of inspection, the manager told us there was no senior upstairs as they "had rung in sick". We asked staff how they managed without a senior carer they said, "We all muck in" and "We just get on with it." One staff member told us, "The new staff are not meant to be with people on their own." Yet we observed two new staff in the dining room assisting people to drink without supervision from other staff and another writing records in the lounge without supervision from other staff. Staff could not confirm when they last had a supervision meeting with the manager or senior member of staff and did not know how frequently they were supposed to be. One member of staff told us the induction period and training was 'adhoc' and said of their role, "It's common sense really, I'm a quick learner so I learnt on the job." There were no clear arrangements in place to ensure staff were adequately supervised and supported during their shift and to ensure that people received safe,

effective and dignified care.

The manager was visible throughout our inspection and demonstrated a good understanding of people's needs and circumstances. We spoke with four visiting healthcare practitioners from specialist services, whose roles were to provide guidance to the manager and staff, about how to meet the specific needs of people. They each told us the manager and staff listened to them and followed recommendations they made. They said staff were caring for people with very complex needs whose behaviour impacted on other people living in the home and on staff's ability to care for them. One of the practitioners said, "Staff do a good job in difficult circumstances. We are constantly reviewing the medicine for one person and their behaviour is unsettled until we get this right. Staff continue to support them as best they can and follow our recommendations during this trial period until we get the right mix of medicine and care in place." A second practitioner said, "Staff are willing to listen and respond positively to feedback."

We saw details of referrals and contact with other services in peoples care records and people told us they had met with healthcare specialists. One person said, "I had a fall or two, and a lady came out to see me, she said I needed a walking frame and this is what she brought me (pointed to a walking frame beside them), I feel much safer now."

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not adequately assess the risks to the health and safety of service users<br>The provider did not do all that is reasonably practicable to mitigate any such risks<br>The provider did not ensure the proper and safe management of medicines;<br>The providers systems for preventing, detecting and controlling the spread of infections were not effective<br>The provider had not ensured that the premises where people lived, were clean and safe to use for their intended purpose |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured that systems or processes were established and operated effectively to -<br>a) assess, monitor and improve the health, safety and welfare of people using or delivering the service. b) assess, monitor and mitigate the risks relating to service users and from the carrying on of the regulated activity<br>c) seek and act on feedback from people on the services provided, for the purposes of continually evaluating and improving such services |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 18 HSCA RA Regulations 2014 Staffing |

| | |
|---|---|
| personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | The provider did not ensure there was sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of people.<br>The provider did not ensure all staff employed by the provider in the provision of a regulated activity received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, |