

Lifestyle Care Management Ltd

# Ashwood Care Centre

## Inspection report

1a Derwent Drive  
Hayes  
Middlesex  
UB4 8DU

Tel: 02085731313  
Website: [www.orchardcarehomes.com](http://www.orchardcarehomes.com)






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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Requires Improvement</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

The inspection was carried out on 29 November, 1 and 5 December 2016 and the first day was unannounced. This was the first inspection under the current registration with the Care Quality Commission which occurred on 4 November 2015. The service was taken over by the new provider as a going concern and staff transferred over, many of whom had worked at the service for several years.

Ashwood Care Centre is a nursing home providing care for a maximum of 70 people. The service has three floors. The ground floor is for people with general nursing and personal care needs, the first floor is for people with nursing and dementia care needs and the second floor is for people with personal care and dementia care needs. At the time of the inspection there were 62 people using the service.

The service is required to have a registered manager. At the time of inspection there was a new manager in post who had commenced on 24 October 2016 and who was going through the application process to become the registered manager. 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.

Risks were not always being assessed to identify the action required to minimise them. People were not always supported in a manner that maintained their safety. Evidence was not available to show the findings of the fire and legionella risk assessments had been addressed.

Staff recruitment procedures were in place but were not always being followed to ensure only suitable staff were employed by the service.

Staff were not always meeting people's social, emotional and leisure needs in a way which reflected their preferences.

Care records were varied with some being comprehensive while others did not identify and reflect people's individual needs, interests and wishes.

The process for auditing and monitoring had not been effective in identifying shortfalls within the service.

The environment had not been reviewed to encompass the sensory needs of people with dementia. We have made a recommendation in respect of this.

The majority of staff demonstrated a caring attitude towards people, however some of the care was task driven and the manager was working with staff to improve the care people received.

Systems and equipment were being serviced and maintained and incidents and accidents were recorded,

investigated and audited to minimise the risk of recurrence.

Procedures were in place to safeguard people against the risk of abuse. Staff understood the importance of keeping people safe and reporting any concerns.

The provider made suitable arrangements to ensure service users were protected against the risks associated with the inappropriate treatment of medicines.

Policies for infection control were in place and were being followed to maintain a clean environment and protect people from the risk of infection.

Staff received training to provide them with the skills and knowledge to care for people effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted.

People's dietary needs and preferences were being identified and met.

People's healthcare needs were identified and they received the input they needed from healthcare professionals.

A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

The manager was approachable and was introducing practices to improve the communication within the service.

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

Some aspects of the service were not safe.

Risks were not always being assessed to identify the action to take to minimise them. People were not always supported in a manner that maintained their safety. Evidence was not available to show the findings of the fire and legionella risk assessments had been addressed.

Staff recruitment procedures were in place but were not always being followed to ensure only suitable staff were employed by the service.

Systems and equipment were being serviced and maintained and incidents and accidents were recorded, investigated and audited to minimise the risk of recurrence.

Procedures were in place to safeguard people against the risk of abuse. Staff understood the importance of keeping people safe and reporting any concerns.

The provider made suitable arrangements to ensure service users were protected against the risks associated with the inappropriate treatment of medicines.

Policies for infection control were in place and were being followed to maintain a clean environment and protect people from the risk of infection.

**Requires Improvement** 

### Is the service effective?

The service was effective.

Staff received training to provide them with the skills and knowledge to care for people effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

The environment had not been reviewed to encompass the sensory needs of people with dementia. We have made a recommendation in respect of this.

**Good** 

### Is the service caring?

Some aspects of the service were not caring.

The majority of staff demonstrated a caring attitude towards people, however some of the care was task driven and the manager was working with staff to improve the quality of care people received.

**Requires Improvement** ●

### Is the service responsive?

Some aspects of the service were not responsive.

Staff were not meeting people's social, emotional and leisure needs in a way which reflected their preferences.

Care records were varied with some being comprehensive while others did not identify and reflect people's individual needs, interests and wishes.

A complaints procedure was in place and people and relatives said they would express any concerns so they could be addressed.

**Requires Improvement** ●

### Is the service well-led?

Some aspects of the service were not well-led.

The process for auditing and monitoring had not been effective in identifying shortfalls within the service.

The manager was approachable and was introducing practices to improve the communication within the service.

**Requires Improvement** ●

# Ashwood Care Centre

## 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 checked 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 29 November, 1 and 5 December 2016 and the first day was unannounced.

Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about. We also viewed the Provider Information Return (PIR) that had been submitted in March 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection team consisted of four inspectors including a pharmacist inspector, a specialist advisor in dementia care, palliative care and nutrition and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. They had experience with older people including those with dementia care needs and of care services for older people.

During the inspection we viewed a variety of records including fifteen care records, some in detail and some to look at specific areas of care, medicines management on all floors and medicines administration record charts for 15 people, four staff recruitment files, three staff training files and the staff training matrix for all staff, risk assessments for safe working practices, servicing and maintenance records for equipment and the premises, complaints records, audit and monitoring reports and policies and procedures.

We used the Short Observational Framework for Inspection (SOFI) on the second floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the mealtime experience for people and interaction between people using the service and staff on all floors.

During the inspection we spoke with sixteen people using the service, seven relatives and other visitors, the manager, two registered nurses, three senior carers, nine carers, the activities coordinator, the chef and two domestic staff including the housekeeper. We spoke with one visiting healthcare professional. Following the inspection we requested feedback from healthcare professionals including members of the Community Adult Rehabilitation Service. We received feedback from the Team Leader of the rehabilitation service with input from four healthcare professionals in the team.

# Is the service safe?

## Our findings

The provider had recorded identified risks for individual people, however the plans to minimise these risks and help keep people safe had not always been reviewed. We saw a record of an incident that identified a risk in respect of the use and storage of sharp items associated with a hobby. Although staff were able to tell us what had been done to address this, they had not completed a risk assessment and there was no plan to identify the action to be taken to minimise the risk, whilst respecting the person's rights. For another person it was identified that they became agitated when their family member left them, however the recorded action plan for staff to follow when this happened, did not include strategies to help to minimise the person's distress. We saw people in bed who were not sitting upright at mealtimes, which could place them at risk of choking.

Risk assessments carried out in respect of fire safety and legionella risk had been completed by external companies. On the fire risk assessment a list of 10 significant findings with a target date of 29 May 2016 had been included. Three points had been addressed by provider's maintenance worker. On the legionella risk assessment 19 primary concerns and 10 secondary concerns had been identified. There was nothing recorded to say if any of the concerns from this or the remaining seven significant findings from the fire risk assessment had been addressed.

On the first day of inspection we observed that one person was in a deep sleep from before 10.50am until 12.20pm. The person had not stirred during this time. At 12.20pm a member of staff approached the person and told them it was time for lunch. The person continued to have their eyes closed. The member of staff told them to stand up and supported them whilst they did so. The person was then supported to walk from their chair in the lounge to the dining room. The member of staff was standing to their side offering support. However, the person's eyes kept closing whilst they were walking and they did not appear to be aware of what they were doing. At one point the person stumbled. Once they were seated in the dining room chair the person went back to sleep. This meant the person had been placed at risk because the staff member did not ensure they were awake and aware of their surroundings before they started to walk. This could have resulted in the person falling and injuring themselves. This was fed back to the manager who said he would address this with staff.

This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were in place but were not always followed to ensure only suitable staff were employed by the service. Application forms had been completed, however in one viewed there was a page missing and there was no employment history listed. From interview notes it appeared the person had only had one previous job in care, however any information contained on the missing page was therefore not available. Only one file contained a completed health questionnaire. Two references were available on each file, however for one member of staff who had previously worked in care, this did not include a reference from the employer. Documents regarding people's right to work in the UK were obtained, however one viewed had expired.

This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks including proof of identity and criminal record checks such as Disclosure and Barring Service (DBS) checks were seen. Action was taken at the time of inspection to gain the missing right to work and reference documents for the staff whose files we viewed and an audit of the recruitment files was organised with the provider's human resources department. The operations director contacted the provider regarding the health questionnaires and was told health information was no longer requested. We discussed the fact this needed to be followed up in order to satisfy the requirements of the Regulations.

Some people were not able to use their call bells because of their disability or capacity to understand what these were for. On one floor there were no recorded risk assessments in relation to this in the care plans we viewed but the procedures followed by the staff helped to minimise the risks of harm. The staff conducted hourly checks to observe them and also attended to people if they called out for assistance. The hourly checks also incorporated checking people who were able to use call bells still had them within easy access to summon assistance.

We saw risk assessments for individuals and these included the risk of developing pressure sores, falls risk, malnutrition risk and risks associated with swallowing difficulties such as choking and included the action required to minimise them. Risk assessments for premises, equipment and safe working practices were in place and these had been completed within the last 12 months so the information was current. Following our feedback the operations director told us they would contact the maintenance company to ensure the findings from the fire and legionella risk assessments were completed.

Records for the servicing and maintenance of equipment were available, including portable appliance testing, gas appliances, passenger lifts, servicing of hoists, adjustable baths and weighing scales. Records for periodic checks such as flushing of little used water outlets, external lighting, first aid boxes, the nurse call system and temperature checks of hot water outlets to ensure these were maintained within safe range were seen, demonstrating that systems and equipment were being checked and maintained. Apart from the one incident we observed staff supporting people in a safe way to move around the service, including those people in wheelchairs and people walking with support or with walking aids. Moving and handling procedures were being followed so people were transferred safely. One member of staff told us, "We always transfer in two's and we get training to do this. We must try and keep dignity in moving."

Incident forms were completed for any incidents and accidents and these were comprehensive and identified the action taken to investigate the event and an action plan to minimise the risk. Accidents and incidents were audited each month and where someone had been involved in more than one incident this was examined to look for any trends, such as time of day, so action could be taken to try and minimise the risk of recurrence.

Policies and procedures for safeguarding and whistleblowing were in place and being followed to protect people from the risk of abuse. Staff confirmed they had received safeguarding training and were clear about the need to report any concerns. Staff knew they could contact other agencies such as the local authority or the Care Quality Commission (CQC) if their concerns were not addressed by the service. During the inspection a person made a comment that indicated they may have been hurt by someone else. One member of staff responded to the person but there was no explanation regarding the comment that had been made. When the manager investigated it became clear the comment was in reference to an historical event and not something that had occurred in the service. The manager said he would speak with staff to ensure any such comments were followed up promptly to ensure people were being kept safe. Where there

had been incidents between two people then these had been reported appropriately to the local authority and CQC.

The service was being staffed to meet the needs of people using the service. We saw staff were available to provide the care and support people required during our inspection. The service had a daily 'flash meeting' and during this staffing in each department was discussed so any projected cover needs could be arranged. Staffing rotas viewed showed cover was being planned, however we noted that some staff were working a large number of hours, for example one member of staff was on the rota for 13 nights without a rest day and another for 13 nights with only one rest day. The manager and the operations director said the rotas would be reviewed and thereafter monitored to ensure staff did not work excessive shifts without a break. We observed that one member of staff was assisting three people during one lunchtime and the manager said this would be reviewed so people had the support they required at mealtimes.

All prescribed medicines were available and were stored securely in medicine trollies in locked clinical rooms on each floor. This assured us that medicines were available at the point of need. Current fridge temperatures were taken each day and staff recorded minimum and maximum temperatures. Fridge temperatures were in the range of 2-8° centigrade and the clinical room temperatures were found to be below 25°centigrade, the appropriate ranges in which medicines were to be stored. Medicines were administered by nurses and senior carers that had been trained in medicines administration. We observed a medicines round on the ground floor and found that staff had a caring attitude towards the administration of medicines for people. Also, we found that staff wore a protective vest to ensure that they were not disturbed during the medicines round and used separate measuring pots for medicines to prevent cross contamination.

People received their medicines as prescribed, including controlled drugs. We found only two gaps in the recording on the medicines administration record (MAR) charts, which assured us that overall, people received their medicines safely, consistently and as prescribed. The two gaps were due to a nurse not signing for the medicine that had been administered. We spoke with one person who reported that they received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, we saw a record of the actual number of dose units administered to the person on the MAR chart. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this, which was in line with national guidance.

Medicines to be disposed of were placed in the appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. We checked expiry dates for medicines and found one medicine that had expired at the end of October 2016. We brought this to the attention of the care home manager who rectified the situation immediately and brought it to the attention of staff through a 'flash' group meeting. Controlled drugs (CDs) were appropriately stored in accordance with legal requirements, with daily audits of quantities completed by two members of staff. We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. For example, we saw 10 PRN forms for pain-relief/laxative medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. People's behaviours were not controlled by excessive or inappropriate use of medicines.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider, including safe

storage of medicines, room and fridge temperatures, CDs and stock quantities checked on a daily basis. The provider had recently improved communication with the Clinical Commissioning Group pharmacist and supplying pharmacy to ensure that external providers would come and audit the safety of medicines within the service. Staff told us that they would like the supplying pharmacy to drop off the monthly medicines in a timelier manner, instead of a couple of days before the start of the new cycle. Currently, should there be any discrepancies in medicines delivered by the pharmacy there was a risk that people would not obtain their medicines at the start of a new cycle. The manager said this had been identified and discussions were taking place to address this.

Policies for infection control were in place and were being followed. We saw cleaning staff throughout our inspection and the service was being kept clean and fresh. The manager was clear about the importance of ensuring personal protective equipment (PPE) such as gloves and aprons and pads to ensure continence care was carried out appropriately were available for use at all times. Systems were in place in the laundry for infection control and cleaning schedules were up to date. Daily fridge and freezer temperature checks were carried out in the kitchen and food was being stored safely. Cleaning instructions for kitchen equipment were available and being followed and the kitchen and laundry areas were clean and tidy.

# Is the service effective?

## Our findings

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

The majority of people living at the service had DoLS authorisations in place and there was an index to identify when these expired so the renewals could be applied for. In one case we found that the condition on the person's authorisation had not been recorded on their care plan, although this was recorded elsewhere. We spoke with the manager about this. The manager said he had discussed the condition with the person and was providing care in accordance with their wishes. The manager agreed to ensure that the care plan was updated with the information. In addition, they told us they would be reviewing all the DoLS authorisations to ensure that any conditions or additional information was recorded in the care plans. Mental capacity assessments had been carried out and identified where people were no longer able to make decisions for themselves, staff were to do so in the person's best interest. We heard staff asking people about their care and support and listening to them, thereby giving them the opportunity to be involved with making choices about the care and support they received.

Staff received training to provide them with the knowledge and skills to care for people. We viewed training records for three staff and they had completed training including infection control, person centred care, moving and positioning, mental health, dementia and disabilities. The online training modules included a test and staff were required to gain 100% in order to pass the module. New staff were undertaking the Care Certificate as part of their induction training. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. The staff were able to talk with us about their training and understood the need to act in people's best interests. One senior carer explained to us the process for people being assessed for DoLS and was clear about why people needed to be assessed under DoLS. We saw on the staff training matrix that all the staff we asked had completed training in MCA and DoLS. The manager had identified that some staff needed additional input and training to improve their knowledge and skills to care for people effectively. The majority of staff we spoke with about their training were able to tell us about this and discuss a variety of topics including mental capacity and acting in people's best interests, safeguarding and infection control and were knowledgeable about them.

People and relatives were happy with the food provision, and comments included, "They give you what you want for breakfast: bacon, sausage, cornflakes, porridge" and "The food is good and well presented." One person who had very specific likes said the service arranged a supply of pasties for them and provided salad,

and this is what they mainly ate so this met their preferences. Information about people's individual food preferences, the type of meal they needed, for example, a normal diet, a pureed diet or feeding a person via a tube and the support they required was recorded. The chef said they were kept informed about people's dietary needs and preferences including any changes and we saw that meals were prepared in line with people's choices. The malnutrition universal screening tool assessment (MUST) was used to monitor people's nutritional status and we saw that people were weighed each month, so their weight was being monitored. Food and fluid charts were completed to monitor people's intakes. People were referred to the dietitian or speech and language therapist for assessment and advice if there were concerns regarding people's weight or eating or swallowing problems.

People received input from healthcare professionals so their healthcare needs could be met. Input from healthcare professionals included from a GP, dietitian, speech and language therapist, chiropodist, palliative care nurse specialist, tissue viability nurse specialist and psychiatry services. We spoke with one healthcare professional who said people were referred in a timely way and that staff took on board advice given and acted upon it. They told us, "I enjoy coming in here. I haven't got any concerns about this home. If I did I would address them." Feedback from other healthcare professionals indicated that referrals were sometimes sporadic, some months with no referrals and then they would receive several in a month. They confirmed staff usually followed advice and instructions given but would like to see more choice, for example with the breakfast options available for people on a pureed diet. We spoke to the manager about these points and he said he would discuss this with staff at the daily flash meetings and use these to monitor the progress in these areas. The service was served by several GPs and the manager confirmed he was mainly happy with this but felt it could be improved by further amalgamating the services so that a single GP practice served each floor.

We viewed the environment on the first and second floors with regards to being dementia friendly. There was limited information for people. On the second floor there was a clock in the main lounge and one in the dining room, however the one in the dining room was showing the wrong time. There was no pictorial guide to show the day, season, weather or staff on duty. There were menus on the tables but these were written and were not correct for one day of the inspection. There were two files of photographed food but the staff did not use these to communicate with people about their menu choices or the food on offer. There were no sensory or tactile elements to the environment. A lot of people spent time walking around corridors but there was nothing for them to interact with or do. There were no activity or sensory resources available for people to help themselves to. For example, there were no items such as dolls or other items of comfort for people to hold. We heard the staff discussing how one person liked to fold things. We witnessed this at the dining table when they spent time folding napkins and the table cloth. However, they were not given anything to fold during the day, which would have provided them with something to occupy some of their time. We spoke with the activities coordinator about items for sensory stimulation and she had a box of different materials that she said she used for this purpose, however this was not left for people to access.

We recommend that the service reviews the National Institute of Care Excellence (NICE) guidance about environments for people with dementia to enhance positive stimulation to enable people living with dementia to see, touch, hear and smell items or objects (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.

## Is the service caring?

### Our findings

We asked people and relatives if they were being well cared for at the service. Comments included, "It's fine. I get on well with all the staff.", "I find it alright... They have certain rules and you've got to follow them. Lunch is at 12:00. They call you when it's time to get up. You can't lie in bed until 11:00.", "They look after us well, of course.", "I'm very happy here. He's [carer] very good.", "It is lovely here, the staff are very nice but I am ready to go home now.", "They're very good here; very kind and very caring and helpful" and "They are sweet, they look after me properly." One relative said, "As far as I know it's alright. We come once a week and everything seems fine. [My relative] tells me if she has any concerns and I talk to them about it and it's all fine." Another told us, "The staff are always nice, they ask how I am too."

The majority of staff demonstrated a caring attitude towards people. However, some of the staff were focussed on the tasks they were performing and did not demonstrate a person-centred approach to care. For example, when some staff served meals they did not communicate with people about the food they were serving or the person's enjoyment of their meal and some staff spent time completing records and did not interact with the people who they were supporting.

On one floor we heard staff saying "good girl" to the people who they were caring for. This term of address was inappropriate and did not show people respect. Immediately after supper, on one day of the inspection, we saw four people in their night attire. We asked one person if they wanted to be in their pyjamas at that time and they answered, "Not really, no!" We saw the staff assisting people with their meals and, in most cases, there was minimal communication and in one instance the member of staff was sitting on the wrong side of the person, so they could not make eye contact or engage with them and the person was looking away and seemed agitated. A senior carer witnessed this and immediately addressed the situation, providing advice and support to the carer and reassuring the person. In another instance we saw a member of staff assisting three people with their lunch at the same time.

On the first day of inspection on the second floor everyone in the dining room was given the same lunchtime meal and no choices were offered. This had improved by the second day of inspection when the operations director was overseeing lunch and they ensured people were given a variety of choices if they did not want the meal options that were available. Drinks were available in the lounges, however we did not see people being offered drinks between meals on this floor. People received drinks at mealtimes and also mid-morning and mid-afternoon and we did not observe people to be expressing thirst, however this needed to be checked to ensure drinks were accessible to people throughout the day. Food and fluid charts were being maintained to monitor people's intake.

We discussed our findings with the manager and the operations director, who told us they were already aware of the issues and were working with the staff to improve the care people received.

We also observed some positive and caring staff attitudes. For example, we saw one staff member supporting a person in a kind and caring way during lunch. They spoke gently to the person, talking about their grandchildren and encouraging them to eat. They took notice when the person said they did not like a

certain food. They allowed the person to take their time. We also saw that some staff approached people in a gentle way and asked about their wellbeing. The staff knew people well, knew their families and knew a bit about their likes, so when they did speak with people they talked about things that interested the person and meant something to them.

The majority of staff communication on other floors with people was warm and friendly, showing caring attitudes, whether conversations were outwardly meaningful or not. Staff referred to people by name, were courteous and friendly and people enjoyed talking with them. All the staff appeared to be enjoying their work, including the domestic staff who were cheerful and busy and who also interacted well with people. One member of staff told us, "You have to do the job with respect and treat them with dignity. They might see you as a family member and they trust you." Another said, "We talk to people and try and see how to help them choose what they like to eat, it is hard, but we try and involve them as much as we can." People looked well cared for and were dressed to reflect individuality.

## Is the service responsive?

### Our findings

The staff were not meeting people's social, emotional and leisure needs in a way which reflected their preferences. We asked people about the activities provision in the service. One person was happy and did not want to join in group activities, however other people told us they were keen to do so but felt there was not enough arranged. Comments included, "We have an activity coordinator but we don't do [any]" and "We just sit." On the first day of inspection we did not see many activities taking place. There was a social interests, hobbies, religious and cultural needs assessment document in people's care records, however some has been partially completed and related care plans had not always been completed to identify how these needs should be met.

Staff on the second floor told us people living at the service did not like or understand organised activities, such as bingo. They said people liked to chat and also enjoyed watching television quiz shows together. However, during the first day of our inspection, with the exception of a small number of interactions, staff did not engage with people and people tended to sit and sleep in chairs or walk about without anything to occupy them. Hourly observation charts viewed on the second floor did not provide much information about the activities people had undertaken and single words were recorded, for example "TV", "sleep", "music" and "walking". We saw staff on the second floor spent a significant amount of time writing in the daily recording booklets and they told us they had a lot of paperwork to complete. People and relatives said the garden was not used and people would like to go on outings but these were not arranged.

Five people were in one lounge on the second floor from 10.50am until 12.20pm. Three other people spent some of this time in the lounge. One person was in a deep sleep for the whole time with no interactions. One person fell asleep at 11.20am and was still asleep at 2.55pm when we left the room. They were roused by staff who asked them if they wanted to have lunch, but apart from that there was no other interaction with the person. Three other people spent the majority of time asleep or with their eyes closed. Only one of these three people had any interactions with others during this time, when they were speaking with another person who was living at the service. The remaining three people in the room were awake for the whole time they were there.

One member of staff was seated in the room with eight people from 10.50am until 11.43am. They only had two interactions with people in the room. One was when the music compact disc started to jump. The member of staff did not initially notice this, but when they did they changed the music saying to people, "Do you want the Christmas music?" The compact disc they put on to play was a one track disc which played on repeat every few minutes from 11am until 11.55am, at which time we alerted the staff that they may wish to change this, which they then did. The other interaction the staff member had was when they said to a person, "What is your date of birth?" The person answered this and the staff member said, "Thank you well done" and then asked, "What is your room number?" The person answered and then said, "But tomorrow I am going home." The staff member then said, "Is it? Ok." The staff member then proceeded to talk to themselves about the record they were looking at, said, "What's the time? Oh God" and then left the room. At midday there were three members of staff in the room and from 12.10pm there were four members of staff in the room. The staff sat and stood together speaking with each other. They discussed that the lunch

was later than planned due to a late delivery of food. They also discussed that the menu had changed. However, the staff did not tell people about this, so people were unaware of the change.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs had been assessed but the quality of information recorded in care plans was variable. Some care plans viewed were very comprehensive. However, in other plans we saw that there was no care plan for a specific need which had been recorded in the person's assessment. The majority of care plans viewed on the ground and first floors were very long and although the information was comprehensive, it was repetitive, for example, elimination needs were recorded under personal care and also under continence care. Care plan information was not easy for staff to read through due to bulkiness and repetition. Care staff said they did not read the care plans because of this and said the nurses provided them with information about people and any changes to their conditions. On the second floor we viewed three care records and in two of these assessment documents had been completed, for example, to identify a person's interests, however a care plan had not been formulated, so there was no information to say how the person's social care needs were to be met. In another record amendments had been made but these were poorly done, so it was not clear what the person's current malnutrition universal screening tool assessment (MUST) score or weight were.

Care records were being reviewed monthly, however comments were general rather than being person-centred and did not always reflect changes in people's care. For example, one person's care plan stated they required two staff to assist with personal care, however the reviews recorded one member of staff and this was confirmed by staff we spoke with. For another person who had been readmitted from hospital and who was being cared for in bed, the care plans had not been updated and still referred to the person being mobile and did not reflect the change in their healthcare needs. A monthly care review had been carried out since their return from hospital, however no changes had been recorded and it was only by speaking with staff that we were made aware of the changes. This could place people at risk of not having their needs met.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they received communion each week and church representatives visited the service. The chef was aware of people with food preferences for religious or cultural reasons and prepared meals to meet these needs. The activities coordinator maintained a record of activities people joined in with and said they spoke with people to find out their interests. There was an activities room on the ground floor with a variety of items and games for activities, however apart from the daily flash meetings we did not see this room in use. We heard a singing session on the ground floor led by the nurse and people were enjoying this and joining in. On the second day of inspection there was a musical activity on the second floor and people were more animated and enjoying themselves. We also saw colouring books but it was a member of staff who was doing the activity. When we asked them about this they tried to engage a person to join in but the person did not seem interested in the activity. The manager said he had identified activities as an area that required work.

The provider had developed a one page 'snap shot' care plan, which could be used to provide care staff with a simple guide to meeting a person's needs. The manager printed these during the inspection and said they would discuss them with staff and put them into use. The manager said the care plans would be reviewed to ensure they were complete and accessible for staff to read.

We viewed records for pressure area care and wound care. People's skin integrity was checked daily and a record made to evidence people's skin condition was being monitored. Dressing regimes were in place for any wounds and we saw records stating that these were healing. We asked staff about the care of people's skin and comments included, "We take pressure sores seriously. Sometimes they come with them, but we work hard to heal them or stop them getting worse" and "We frequently monitor skin during personal hygiene time, and we look for any problems. Then we would work to lessen progress of complications and aim for recovery of good skin integrity." Where people were at risk of developing pressure sores, repositioning charts were in place and we saw these had been completed to evidence that people's positions were being changed regularly as part of their care routine.

We viewed records for baths and showers and saw there was no record for several people during the previous month. We asked a senior carer about this and they said people often refused to have a bath or shower and this was indicated with a code on the daily records, which we saw. People looked clean and cared for and were well dressed.

The service had a complaints procedure and this was available for people and visitors to follow so that complaints could be addressed. The manager said he encouraged people and visitors to raise any issues so they could be addressed. There had been one complaint recorded since the provider took over the service and this had been investigated and responded to. Relatives said they would feel confident to raise any concerns they might have so they could be addressed.

# Is the service well-led?

## Our findings

The provider had systems in place for monitoring the service, however these were not effective. During our inspection we identified shortfalls in several areas. These included risk management, staff recruitment, care planning, activities provision and person-centred care. The auditing and monitoring processes were not robust and so shortfalls were not always being identified and addressed, which placed people at risk.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a monitoring team who carried out quarterly visits to the service. The reports and action plans from these visits were not available for us to view during the inspection and we were sent the report from the September 2016 visit following our inspection. The report had picked up some areas that had since been addressed, for example, the need for mental capacity and best interest assessments to be carried out and better monitoring of pressure sores, which had led to improvements.

There were internal audits carried out monthly at the service and these included checks of equipment in use including bedrails, pressure mattresses and cushions and pillows. They also audited medicines, weights, pressure sores, occurrence of infections, accidents/falls and skin tears and also recorded the action being taken to address any issues identified. These audits evidenced progress and monitored improvements in each area.

People were positive about the manager and knew who he was. One person said, "The manager seems okay. He's new. He comes to talk to us in the dining room." Staff said the manager was approachable and supportive. One told us, "I can talk to this new manager." The manager was seen around the service during the inspection and had communicated well with people and staff. Staff were positive about the manager's style and said he was 'approachable'. Staff reported they would feel able to whistle blow or make suggestions/complaints if necessary. The manager was open and responsive to our feedback and said they would work to address the shortfalls identified.

Staff confirmed they received one to one supervision every two to three months to discuss their work and training and development and felt supported by their seniors. Those who had been at the service over 12 months also had annual appraisals to monitor their progress and identify any areas for development.

The manager had introduced daily 'flash meetings' and these were attended by all the heads of department including the nurses on the ground and first floors and the senior carer on the second floor. Each person had the opportunity to flag up any areas for discussion that day and information was being shared between departments. For example, staffing was discussed to ensure any shifts needing cover were identified and arrangements made to maintain the staffing levels to meet people's needs. Health and safety issues were discussed including any servicing and maintenance to be carried out that day. Other topics discussed included infection control, skin integrity, activities and any people whose needs had significantly changed and who needed more care and support. Staff said these meetings were valuable and provided them with a

picture of what was going on throughout the service. Staff felt involved and informed. Staff meetings took place every two or three months for all departments and minutes were available. Staff said communication had improved in the service and they were encouraged to give their opinion on matters and were listened to. Relatives meetings also took place and the manager said he encouraged people and relatives to speak with him if they had any points to raise so they were known and could be addressed. We discussed satisfaction surveys and the manager said there had not been a big response to the last survey so he was carrying out a new survey for people, relatives and stakeholders.

The manager was an experienced care home manager and had identified the importance of effective communication in all areas of the service in order that any issues could be identified and addressed. We discussed the development plan for the service. The manager was waiting to receive this from the provider so we were not able to view this at the inspection.

Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

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  Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care  The registered person did not:  1. <input type="checkbox"/> Carry out adequate assessments of the needs and preferences of service users. 2. <input type="checkbox"/> Design care or treatment with a view to achieving service users' preferences and ensuring their needs are met.  Regulation 9(1) and 9(3)(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care  Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The registered person did not:  1. <input type="checkbox"/> Assess the risks to the health and safety of service users of receiving the care or treatment. 2. <input type="checkbox"/> Do all that is reasonably practicable to mitigate any such risks.  Regulation 12(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care  Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance  The registered person did not:  1. <input type="checkbox"/> Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

2. □ Maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided.

Regulation 17(2)(a)(c)

## Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

## Regulation

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The registered person did not operate recruitment procedures effectively to ensure the required information was obtained for people employed at the service.

Regulation 19(2)(3)(a) and Schedule 3