Claregrange Limited

Aslockton Hall Nursing & Residential Home

Inspection report

New Lane
Aslockton
Nottingham
Nottinghamshire
NG13 9AH

Tel: 01949850233
Website: www.aslocktonhall.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 March 2016 and was unannounced.

Accommodation for up to 62 people is provided in the home over two floors. The service is designed to meet the needs of older people. There were 52 people using the service at the time of our inspection.

A manager was in post and had started in January 2016; however she was not yet registered with CQC. She was available during the inspection. An application to register with the CQC had been made by the time of our inspection. 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.

Prompt action had not been taken to respond to a potential safeguarding issue. Identified risks to people were not always managed safely. Sufficient numbers of staff were not on duty to meet people's needs. Safe infection control and medicines practices were not always followed. Staff were recruited through safe recruitment practices.

Staff did not receive appropriate training, supervision and appraisal. People did not always receive sufficient to drink and people's nutrition and hydration risks were not always managed effectively.
People's rights were not fully protected under the Mental Capacity Act 2005. People's needs were not fully met by the adaptation, design and decoration of the service. External professionals were involved in people's care as appropriate, but it was not clear that people were being appropriately supported when at risk of skin damage.

Some staff were caring but most interactions with people were task focussed. People were involved in decisions about their care but relatives did not always feel they were informed or could ask questions. Advocacy information was not made available to people. People were not always treated with dignity.

People did not always receive personalised care that was responsive to their needs. Activities required improvement. Care records did not always contain information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service. However, their comments were not always acted upon. The provider was not always sending notifications to the CQC when required. Staff told us they would be confident raising any concerns with the manager and that they would take action.

We found 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 this 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?

Inadequate

The service was not safe.

Prompt action had not been taken to respond to a potential safeguarding issue. Identified risks to people were not always managed safely.

Sufficient numbers of staff were not on duty to meet people's needs. Safe infection control and medicines practices were not always followed.

Staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive appropriate training, supervision and appraisal. People did not always receive sufficient to drink and people's nutrition and hydration risks were not always managed effectively.

People's rights were not fully protected under the Mental Capacity Act 2005. People's needs were not fully met by the adaptation, design and decoration of the service.

External professionals were involved in people's care as appropriate, but it was not clear that people were being appropriately supported when at risk of skin damage.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were caring but most interactions with people were task focussed.

People were involved in decisions about their care but relatives did not always feel they were informed or could ask questions. Advocacy information was not made available to people.

People were not always treated with dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs. Activities required improvement.

Care records did not always contain information to support staff to meet people's individual needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor and improve the quality of the service provided, however, they were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service. However, their comments were not always acted upon.

The provider was not always sending notifications to the CQC when required.

Staff told us they would be confident raising any concerns with the manager and that they would take action.

Aslockton Hall Nursing & Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 March 2016 and was unannounced. The inspection team consisted of an inspector and a specialist nursing advisor with experience of dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted visiting health and social care professionals, the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with eight people who used the service, seven visitors, a visiting healthcare professional, a housekeeper, a laundry staff member, two senior carers, one care staff member, two nurses, the manager and the nominated individual. We looked at the relevant parts of the care records of 11 people, three staff files and other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

Most people told us they felt safe. A person said, "Of course I feel safe, there is no reason why I shouldn't." Another person said, "I've not heard a raised voice." Visitors told us their family members were safe. A visitor said, "I have no concerns about safety."

We spoke with a person who used the service who became upset while talking with us but would not explain why. We raised this with the manager who later in the inspection informed us that a staff member had been made aware of an incident involving the person and had not informed the manager. A safeguarding referral had not been made and prompt action had not been taken at the time of the incident. The manager made a safeguarding referral following our visit.

A safeguarding policy was in place but it did not contain sufficient detail as it did not include any reference to referring issues to the local authority safeguarding team. Staff we spoke to were aware of the signs and symptoms of abuse and told us if they had a concern they would report it to the nurse, the deputy manager, or the manager. A large proportion of staff had not attended safeguarding adults training or needed to update this training. Information on safeguarding was not displayed in the home to give guidance to people and their relatives if they had concerns about their safety. This meant that there was a greater risk of potential abuse being identified or acted upon as effective systems were not in place to support staff to identify and act upon potential abuse and for people and their relatives to report any potential abuse to the relevant authority.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were not always managed so that people were protected and their freedom supported. Individual risk assessments had been completed to assess people's risks of falls, developing pressure ulcers, malnutrition and moving and handling risks. However, these were not always reviewed regularly to ensure they remained an up to date assessment of people's risks.

Accidents and incident forms were well completed with clear actions identified and taken. We saw when a person had fallen, an accident/incident form had been completed along with a body map and falls checklist. However, a standardised mobility care plan was put in place for all people with no personalised information to reduce the risk of further falls in the future. Another person had fallen a number of times. Their risk assessment had not always been reviewed in response to individual falls and again detailed information was not in place to address their risk of falling in the future.

Pressure relieving equipment was in place as necessary and we noted pressure relieving mattresses were set appropriately for the person using them. When asked if there were any improvements needed at the home, a member of staff said, "Some decent equipment, some electric hoists and a new rotunda. It is hard to wheel and keeps taking the carpet up." Other staff also commented on the age of the hoists and difficulties in moving people smoothly using them. We observed staff using hoists to move people and saw they used safe

techniques but the process was slow and jerky. A person raised concerns about the hoist.

We saw that the premises were not safe and secure. People could leave the home through the front door as it was not restricted and it would be possible to leave the building unobserved. This presented a risk to those people who would not be safe if they left the building unsupervised.

Hazardous materials were not always safely stored which included nail varnish remover and cleaning materials. We observed that thickening agents for people who required thickened fluids were kept in people's bedrooms and in communal areas where it was possible for people to access it. There has been a national safety notice advising how these agents should be stored to restrict access. If these products were consumed they could cause harm.

We saw that the surfaces of heaters in corridors were very hot and put people at risk of avoidable harm as they were not covered. We also saw a bathroom window on the first floor which had not been restricted and an open store room with walking frames above head height which could be pulled down. A person's care plan stated they had refused to have protectors on their bed rails as it made them feel 'closed in'. We saw the bed rail was in place without the protectors and asked the person about this as there is an increased risk of injury if the protectors are not used. The person said no one had asked them about using protectors and they had not refused them. We asked the manager to talk with the person about this to ensure that the person was not put at risk of avoidable harm.

Checks of the equipment and premises were generally taking place, however, water temperatures were last carried out in January 2016 and wheelchairs were being checked just twice a year. This meant that there was a greater risk that issues would not be promptly identified putting people at risk.

A business continuity plan was in place but did not include all necessary details to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency.

People told us there was not always enough staff to meet their needs. A person said, "I think the care staff are under enormous pressure. I don't think they have time to read care plans as I always have to ask to have my teeth cleaned and my arms and legs creamed." Another person said, "I think they could do with more staff. [Staff] mostly come quick, it depends if there are other things going on. At night time you wait because things happen at night. You have got to wait for assistance." A visitor said, "Staffing levels are not good. Staff are rushing around." Another visitor said, "They are so busy, there really is insufficient staff."

A nurse said, "Staffing has been a massive issue since December. It is really difficult to recruit." Another staff member said, "There is a big question mark about staffing at the moment. Sometimes there aren't enough staff." Another member of staff said, "Lately we have been short staffed. It is frustrating. The top priority care gets done but we can't spend time with [people using the service]."

We observed that people did not always receive care promptly when requesting assistance. On the second day of inspection, we saw that a number of bells were sounding at the same time. We overheard a staff

member saying to a visitor, "[The call bells] are always crazy after breakfast." We observed a person wait 20 minutes before their buzzer was answered. We saw that it was noted in documentation, "[Person's name] bath not given as [type of bath] needs 2 carers." This suggested that staffing levels had meant that sufficient staff were not available for a person to receive a bath. A staff member had told us that staffing levels sometimes meant that people who liked to receive two baths a week would only receive one bath. Another staff member said, "If [people who use the service] are not adamant they want a bath then they don't get bathed. Something has to give."

Robust systems were not in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The service did not use a dependency tool to review the dependency of people or a staffing tool to give guidance on the staffing requirements. This has a direct impact on people receiving timely safe care and support.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People told us that they received their medicines safely. A person said, "Staff bring my tablets on time." Another person said, "They're [staff] good with my tablets." A visitor told us that their family member had not received a medicine on time once as staff had not had time to check the medicines which came with the person when they returned to the home from hospital. However, most visitors said they had no concerns about medicines.

We observed the administration of some people's medicines and saw they were administered safely in line with requirements. However, we had concerns about the length of time taken for medicines to be administered in the morning as the medicines round had started at 8am and medicines were still being administered after 11.30am on the first day of our inspection on both floors. We could not be confident that regular intervals were maintained between other medicines which were prescribed to be given three or four times a day.

Some people would not have been offered as required medicines, such as pain relief, until late morning which meant they would have had an extended gap overnight. This may have reduced the effectiveness of the medicines and put people at risk of pain. The manager said, "The medicines rounds take three to four hours in the morning – it's horrendous."

Medicines Administration Records (MAR) contained a front page with a photograph of the person to aid identification and a record of the person's allergies and their preferences for taking their medicines. All the prescribed medicines were handwritten on the MAR for each person as pre-printed MARs were not supplied by the pharmacy medicines supplier. This introduces an increased risk of errors occurring with transcription and issues with legibility. However, all the entries had been checked by a second person to ensure accuracy of transcription and the entries were clear and legible.

PRN protocols were not in place to provide information on the reasons for administration of medicines which had been prescribed to be given only as required. This meant there was the possibility of inconsistency in the reasons for administration of these medicines. Some liquid medicines and topical creams were not labelled with their date of opening as required to ensure they were not administered past

their effective date.

Processes for the ordering and supply of medicines were unclear and as a result there was an increased risk of medicines not being available for people when they were needed. There was no established rotational cycle for the ordering of all medicines and people's medicine cycles started on different weeks. When we asked staff about the mechanisms for ordering and supply, the process they described differed and there was a lack of clarity. Staff admitted there were frequent occasions when medicines were not available to be administered for one to two days due to the stock running out, which included antibiotics. We saw there were numerous occasions when homely remedy stocks of paracetamol had had to be used because the person's own supply had run out.

Most medicines were stored in locked trolleys, cupboards and refrigerators within a locked room. Temperatures of the storage areas were recorded daily and were within acceptable limits. However, enteral feeding supplies and nutritional supplements were stored in a separate unsecure cupboard and the temperature of this cupboard was not recorded.

Two errors in the administration of a person's enteral food had occurred within a few days of one another. Steps had been taken as a result to separate the enteral foods for the person involved from the enteral foods for another person at the service to prevent the error occurring again. However, we were informed following the inspection that this error had occurred again.

The new manager was open about the issues and had identified most of them herself prior to the inspection. As a result, the service was negotiating a move of pharmacy supplier to address the problems and establish clear systems for medicines management.

Only registered nurses administered medicines and they told us they had completed training in medicines administration and had had their competency assessed. We checked the competency assessments and saw the staff on day duty had completed a competency assessment in the last year but staff doing night duty had not. When medicines errors had occurred, competency assessments had been completed for the staff involved. Training records showed that not all nurses had attended medicines training or received medicines competency assessments.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the home was clean. A person said, "The home is immaculate." Another person said, "It's very clean." A visitor said, "Cleanliness is excellent." Another visitor said, "Cleanliness is mostly exceptional." Staff were able to clearly explain their responsibilities to keep the home clean and minimise the risk of infection.

During our inspection we looked at all bedrooms, all toilets and shower rooms and communal areas. We saw that areas were clean but some areas and equipment would be difficult to keep clean due to deterioration in their condition. This included an overlap table, ripped flooring in a bathroom, a deteriorated surface in the hairdressers and some grouting in a bathroom requiring re-doing. We were also concerned that a portable suction machine was stored in a cupboard and there was no system in place to ensure it was clean before use. We also observed that staff did not always follow safe infection control practices. One staff member handed people biscuits using their fingers and placed them directly onto tables not plates.

Requires Improvement

Is the service effective?

Our findings

Almost all people told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "Excellent without exception." Another person said, "Staff are excellent. Couldn't wish for better ones." However, another person felt that staff needed more training.

Visitors told us that they felt that staff were competent and knew what they were doing. A visitor told us they felt staff carried out their role well and commented on the positive feedback they had received about the person's skin condition when they were admitted to hospital. However, we observed that staff did not always demonstrate that they were competent in the areas of safeguarding, managing risk, medicines, infection control, DoLS, nutrition and hydration, dignity and activities.

Staff felt supported by the manager. They told us they had received an induction. However, induction documentation was not always fully completed to show that staff had completed all parts of their induction. This meant it was not clear that staff had received a full induction to their role.

Staff told us they felt they had the knowledge and skills they needed for their job role, however, a staff member told us they had not completed safeguarding training since coming to the service three years previously. Training records showed that there were significant gaps in the courses that staff had attended which included equality and diversity training. Approximately 40% of care staff and nurses had not received moving and handling training, 80% of domestic staff had not received infection control training and approximately 60% of kitchen staff had not received food hygiene training.

Staff were mixed in their responses to frequency of staff supervision meetings. A staff member told us they received regular supervision. However another staff member told us had not had a formal supervision meeting for over six months. The supervision matrix showed that approximately 50% of staff had not received recent supervision. It was not clear whether any staff had received an appraisal. This meant that not all staff were receiving sufficient support to carry out their role effectively.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the food choices available and told us that they received meals that met their needs. A person said, "The food is very good."

We observed the lunchtime meal on both floors. Tables were set with tablecloths, table mats and serviettes. However, there were no condiments on the tables for people to use. Meals were brought to the dining rooms already plated and covered on a trolley. They were distributed efficiently, but generally placed on the table with little communication or explanation. There were also no menus for people to choose from.

Staff sat with people who needed assistance at their level and provided occasional encouragement to people to eat. However, sometimes there was little explanation for people about what was on the plate and

little communication with them. We also saw that a staff member assisted two people at the same time which is not good practice.

We had serious concerns about three people's fluid intake. When we checked the documentation related to their care and their food and fluid intake, we found they indicated very low amounts of fluid had been consumed by these people over a period of several days. We also found some people's charts indicated a low urinary output which if accurate, would also suggest their intake was low. Staff had not identified these concerns. We asked the manager to make safeguarding referrals for three people and they did.

Staff told us that drinks were left with people who used the service by the person with the drinks trolley. People who required assistance were then reliant on care staff to come and assist them to drink. This system did not appear to be working as we found full beakers of drinks by people's bedsides unconsumed. Three relatives told us they had some concerns about staff providing assistance as when they had visited they also found several full cups of drink by people's bedsides.

Robust systems were also not in place to ensure that people at risk of choking received appropriate fluids. When we asked two of the staff distributing drinks which people were on thickened fluids they were able to tell us. However, one staff member told us that as the people requiring thickened fluids needed assistance from care staff to drink, the care staff would thicken the fluids, whilst other staff told us that the staff distributing the drinks knew who needed thickened fluids and would thicken the drink. This meant that there was a risk that people's fluids would not be thickened when necessary.

People's weights were not being appropriately monitored. A visitor told us that their family member was not being regularly weighed. This person had been referred to a dietician as they had a deep pressure ulcer which would affect their nutritional needs. The dietician had recommended that the person was weighed two weekly but we did not find any evidence of this happening. The person's relative told us they had asked for the person to be weighed but this did not appear to have been acted on. Another person had also been referred to the dietician and two weekly weights recommended but this was not taking place. We looked at the documentation for weights and saw that saw that there were no documented weights for people living upstairs for December 2015 and February 2016.

These were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a staff member moving a person using a hoist. They clearly explained what was taking place and checked with the person before doing something. However, we saw that other staff did not always explain what they were about to do before assisting people. A visitor said, "Staff have not done anything against [my family member's] wishes."

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 DoLS. We checked whether the service was working within the principles of the MCA.

The requirements of the MCA were being followed as when a person lacked the capacity to make some decisions for themselves; a mental capacity assessment and best interests documentation had been completed. When people were unable to make some decisions for themselves an assessment had been carried out identifying the reasons why they were unable to make decisions in relations to a number of aspects of their care and support. However documentation was unclear at times regarding whether a person had a power of attorney in place and what type of power of attorney was in place. This meant that there was a greater risk that appropriate people would not be involved in the decision making process. We also saw that DoLS applications had been made for only three people who used the service. Our experience of people during the inspection suggested that there may be more people that required a DoLS application to be made. This meant that there was a greater risk that people's rights were not being protected.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place but they had not always been completed appropriately to demonstrate that the person had been involved in the decision or fully completed to show they lacked capacity.

People told us they were supported with their health care needs. A visitor said, "[My family member] sees the GP and the chiropodist." A visiting professional told us that staff requested advice appropriately and followed guidance correctly.

People's care records demonstrated they had access to a range of professionals such as a Speech and Language Therapist, the GP, nutrition service, and continence advisor. Staff told us they had a good relationship with the local GP practice and the local GP visited the home regularly.

We talked with a person who was unable to move their position themselves. They told us they were comfortable and staff assisted them to move their position. We talked with a relative of a person who was confined to bed and had complex needs. The relative told us the person had been admitted to hospital recently due to a problem which had arisen and staff at the hospital had commented on the fact the person's skin was in such good condition. They said this indicated that they were receiving good pressure area care. We saw care was documented for this person, indicating they were being re-positioned regularly and their continence needs managed.

However we saw that documentation for three people who required position changes did not demonstrate that staff supported them to change position to meet their identified needs. One person had a gap of 13 hours between positional changes, another had gaps of 10 hours and another person had gaps of over five hours. Two staff we talked with said re-positioning was given priority when they were short of staff but they felt that sometimes documentation was not completed.

We reviewed the records relating to the care of a person's pressure ulcer. We found a wound management care plan was in place and a record of the dressings being replaced in accordance with this. Regular assessments of wound healing had been carried out and photographs had been taken at intervals to demonstrate the progress of the wound. A tissue viability referral had been made.

Adaptations had not been made to the design of the home to support people living with dementia. People's bedrooms were not clearly identified. Handrails were the same colour as the surrounding walls and would be difficult for people with visual difficulties to distinguish. Bathrooms and toilets were not clearly identified and there was no directional signage to support people to move independently around the home.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind. A person said, "Staff are very supportive and caring." Another person said, "Staff take time and are patient with you." A visitor said, "The staff are excellent and caring. They give people all the time in the world and don't rush interactions."

A visitor told us that staff knew their family member's needs. A visiting professional told us that staff knew people well. From talking with staff we concluded most staff knew people and their needs.

The interactions between staff and people using the service were very variable. We saw some very positive interactions by staff, who explained things clearly and showed understanding and empathy for people. However, most interactions were task focussed and some staff had very little interaction with people at all. For example we saw a member of staff serving drinks to people in the lounge. They brought people a hot drink without giving them a choice and left it on the table by them. They offered them a plate of biscuits. If they did not respond the staff took a biscuit from the plate and placed it beside them on the table. There was hardly any communication with people at all.

Two people told us they had been involved in care planning. However visitors' views were mixed. Some visitors told us that they were fully involved in care planning and had regular reviews of their family member's care. Another visitor remembered being involved in care planning when their family member first arrived at the home but could not recall being involved since. Two visitors told us they felt they were not always kept informed about their relative's care and that when they asked questions, these were not welcomed by some staff. One told us staff had said to them, "They were only a visitor and [staff] did not have to explain to them." Both said staff had told them they had considerable experience at the service and they knew better than the visitor. They felt it was difficult to ask for information or ask questions because of this.

Care records indicated people had been involved in the reviews of their care plans and documents were either signed by the person or they stated the person was unable to sign but had understood or participated. Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us. However, advocacy information was not available for people if they required support or advice from an independent person.

People felt that their privacy and dignity were respected. A person said, "The staff are friendly and polite." Another person said, "Staff are respectful." Visitors felt that their family members were treated with dignity and respect.

Staff told us they closed the door when providing personal care and ensured people were covered as much as possible. They said they knew people's preferences in relation to their personal care and whether they had preferences for a same gender staff member. However, a male staff member said they would normally ask if the person was happy for them to do their personal care and would find someone else if required.

We observed two people being transferred using a hoist. People's dignity was not protected during the

moves as one person's underwear could be seen due to their position in the hoist. The other person had bare flesh exposed due to the person's clothing riding up their back (due to the position of the sling). Staff did not notice this. We also saw staff talking about people in front of other people on a number of occasions. We also overheard a staff member talking about a person to two other staff saying, "She's being a bit demanding today."

The home had a number of areas where people could have privacy if they wanted it. Care records were stored securely. However not all toilets had locks or signs to show whether they were engaged or not.

People were supported to eat their meals independently and plate guards were used. Staff told us they encouraged people to do as much as possible for themselves to maintain their independence.

Staff told us people's relatives and friends were able to visit them without any unnecessary restriction and people we spoke with confirmed this was the case. A visitor told us there were no restrictions on visiting times.

Requires Improvement

Is the service responsive?

Our findings

A person told us they could get up and go to bed when they liked. Another person said that they had an excellent response from staff to their requests. However a visitor said their family member did not receive care that was responsive to their needs. They said, "Breakfast is so late here." They told us their relative had been used to having their breakfast at around 7.30am and breakfast was being served to them in the home between 9am and 9.30am and then lunch was relatively early at around 12.15pm.

We observed that people did not always get the support they needed at the time they required it. We observed that a person waited 52 minutes after finishing their meal to be supported by staff to leave the dining room. We saw that buzzers were not always responded to promptly.

We asked a person using the service about activities at the service. They said, "Things go off downstairs and you can be asked to be taken down." They said, "In the summer there is more going on, in the winter it is not very lively."

A relative of a person who stayed in bed in their room said the person did not get any one to one time with staff and they said they would have liked staff to have some time to sit with them and talk to them. Another relative gave similar feedback and said, "Today when I came in the curtains were drawn and [the person] had been left in a dark room with no television on." They told us this had happened before and they had asked for the curtains to be drawn back and the television put onto channels their relative enjoyed. They said staff had told them the sun had been shining directly into the room and so they had drawn the curtains to prevent the person overheating. The relative went on to say, "No one ever spends any time with [the person]. [The person] is stuck there with nothing at all to do or see." They told us when they came in they put make up on their relative and painted their nails as the person had always enjoyed that but staff did not do that. They said staff had commented, "There's only three of us and we can only do what we can do."

Staff told us they felt there were enough things for people to do and said there were usually activities in the downstairs lounge after lunch most days.

We saw very little activity taking place during our inspection. We did not see any activities led by staff during our inspection. Activity records were not maintained for each person so the service could not demonstrate that people's individual needs were being met in these areas.

An initial assessment of people's care and support needs had been completed and re-assessments completed within the last three months. A range of care plans were in place for all aspects of people's care and support. However, we found many of these contained only generic, standardised information which did not provide any information about people's specific needs. It would not have been possible to identify the care and support the person required based solely on these care plans. The monthly evaluations which had been completed contained more personalised information and provided a better description of the person's needs, however, as a result it was necessary to read a considerable amount of material to gain an understanding of the person's needs. If an attempt had been made to provide care on the basis of the care

plan alone, sufficient information was not available. Some care plans had been added to a recent review giving more personalised information and there was evidence of the manager having reviewed the plans. There were also notes to staff to add additional information and gaps were identified.

When people had continuing health needs care plans were in place to identify the care required to manage these. There was a urinary catheter management plan in place and a record of catheter changes for people with catheters. However, although when people had their nutrition via a PEG tube there was clear guidance in place, we did not find care plans for the management of their tube and the tube site. One person had had to visit the hospital due to a blocked tube but there was no plan to identify initial action which could be taken by staff if the tube blocked in the future.

We reviewed the care plans of two people with diabetes. We found their nutrition care plan made no reference to their diabetes except in one of the monthly evaluations where both stated they were on a normal diabetic diet. They both had generic diabetes care plans which were not personalised and gave no information about the frequency of blood glucose monitoring required, or the signs and symptoms of hypoglycaemia, or the higher and lower blood glucose levels which would trigger action by staff. Frequency of monitoring of blood glucose levels was mentioned in one of the monthly evaluations.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person said, "I would go to the manager if I had any concerns." However, we asked another person using the service if they knew how to make a complaint if they were unhappy with the care provided. They said, "I don't think I would as it wouldn't go down well." A visitor told us they would go down to the office to make a complaint. Another visitor told us that they had raised a concern and were satisfied with the response they received. Staff were able to explain how they would respond to complaints.

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed in the main reception area. A complaints policy was in place but did not contain contact details for the local Government Ombudsman.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system to regularly assess and monitor the quality of service that people received, however it was not fully effective as it had not identified and addressed the issues we identified at this inspection.

The manager told us that food, fluid and position charts should be reviewed by staff each day to check that people were receiving sufficient to eat and drink and support to change their position in line with their care plan. However we saw that this system was not working. We also saw that the gaps in training and supervision had not been identified and addressed prior to our inspection.

Some care plans had been audited in January 2016. We saw that limited weekly and monthly checks were carried out by the manager. The tool used was not detailed and would be unlikely to effectively prompt the manager to identify issues. The medication audit was also poorly structured and would not be effective in identifying issues. An infection control audit was not being carried out. The manager was starting to introduce new systems of working and audits but these were not fully effective by the time of our inspection.

We spoke with the nominated individual. They told us that they visited the home regularly; however, they did not produce any reports of their visits. This meant that it was not clear what systems they had in place to assess the quality of the service.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meetings for people who used the service and their relatives took place. However, we saw that at the meeting in December 2015 it was noted that, 'One relative felt drinks were not being given by staff that had been left by kitchen staff on the morning round.' We found this same issue during this inspection suggesting that appropriate action had not been taken in response to the feedback. We also saw that a report had been produced by an external organisation who had visited the home to gain the views of people living there. This report contained comments from people regarding staffing levels and the activities available in the home. Again we found these same issues suggesting that appropriate action had not been taken in response to the feedback.

Visitors told us that their views were asked for and responded to. A visitor told us they had completed surveys and were aware of meetings they could attend. Another visitor told us they had completed a survey and received feedback. A suggestion box was also in the main reception area.

A whistleblowing policy was in place but did not contain sufficient detail to assure staff that they would not suffer detriment if they raised issues in good faith. However, staff told us they would be comfortable raising issues using the processes set out in this policy.

Staff we talked with were committed to their job. A nurse said, "The carers are absolutely brilliant." They

went on to say, "In the main we give really good care. The relatives are more than happy." A staff said, "The atmosphere is lovely and the management is good. Everyone is very friendly; we work as a team." Another member of staff said, "It is a really nice place to work. I was worried about coming here but everybody gets on."

People and visitors were very positive about the manager. A person said, "Yes, I see the boss, she's very easy to talk to." Visitors told us that the manager was accessible and approachable.

Staff told us they felt the leadership of the home was good. A staff member said, "[The manager] has such a strong view of what needs to be done, she will get it done. She's up to date, but she needs everybody on her side." Another staff member said, "What she has done already is amazing. I can't fault her. She is strong and knowledgeable." Another staff member said, "[The manager] is doing a good job, she is getting there. She is working with us. She is always on patrol." When we asked if that was good or bad they said, "Good. She makes sure everything is ok."

We saw that regular staff meetings took place and the manager had clearly set out her expectations of staff. Staff views had been gathered by the manager using surveys. Staff raised a number of issues regarding staffing levels. One survey said, 'There is no dignity in one carer walking around a table feeding four residents.' Another survey, 'I would not place my family member at the home with staffing levels as they are at the moment.' Another survey, 'Every shift I work is short staffed… We have worked short staffed for many months now …' They also stated that they wouldn't place a family a member at the home as, '… the level of care is currently declining.' We looked at nine questionnaires and seven raised staffing levels as an issue. We found this same issue at this inspection suggesting that appropriate action had not been taken in response to the feedback.

A manager was in post and had started in January 2016; however she was not yet registered with CQC. She was available during the inspection. An application to register with the CQC had been made by the time of our inspection. She clearly explained her responsibilities and felt well supported by the provider. She told us that sufficient resources were available to her to provide a good quality of care at the home. We saw that all conditions of registration with the CQC were being met, however, statutory notifications were not always being sent to the CQC when 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care 1.The care and treatment of service users must— a.be appropriate, b.meet their needs, and c.reflect their preferences. Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 1.Care and treatment must be provided in a safe way for service users. 2.Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— a.assessing the risks to the health and safety of service users of receiving the care or treatment; b.doing all that is reasonably practicable to mitigate any such risks; g.the proper and safe management of medicines; Regulation 12 (1) and (2) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

Diagnostic and screening procedures Treatment of disease, disorder or injury	improper treatment 2.Systems and processes must be established and operated effectively to prevent abuse of service users. 3.Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Regulation 13 (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 1.The nutritional and hydration needs of service users must be met. 4.For the purposes of paragraph (1), "nutritional and hydration needs" means— a.receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health, and d.if necessary, support for a service user to eat or drink. Regulation 14 (1) and (4) (a) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance 1.Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Regulation 17(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing 1.Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

2.Persons employed by the service provider in the provision of a regulated activity must—
a.receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Regulation 18 (1) and (2) (a).