Ashbourne Court Residential Care Home Limited

Ashbourne Court Care Home

Inspection report

Ashbourne Close
Ash
Aldershot
Hampshire
GU12 6AG

Tel: 01252326769

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13 January 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashbourne Court is a residential care home providing accommodation, personal care and support to up to 16 people. The home is located in a quiet residential area. The accommodation is set over two floors with a stair lift available. At the time of our inspection there were 11 people living at the home.

The inspection took place on 13 January 2016 and was unannounced.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

The service did not deploy sufficient staff to meet people's needs. People assessed as being at risk of falls were left unattended whilst staff carried out domestic tasks. Staff were not always available to offer reassurance to people and we observed people spent significant amounts of the day asleep. People were not provided with a range of activities which reflected their hobbies and interests.

Systems were not in place to ensure people were protected from the risks of infection control. Procedures to ensure adequate and appropriate cleaning equipment was available were not in place.

People's legal rights were not always protected. Two people's bedroom doors were locked at night with other rooms being locked during the day preventing them from re-entering them.

Staff did not always receive the appropriate training to ensure they had the relevant skills to meet people's needs. Not all staff had received training in supporting people living with dementia and this was evident in their practice.

Regular audits of the service were not completed to monitor the quality and effectiveness of the service. There was a complaints procedure in place and we saw that complaints had been responded to in a timely manner. However, systems were not implemented to ensure that concerns raised did not reoccur. Staff and people were not routinely involved in decisions about how the home was run.

Records of the care people received were not always completed by the staff who had delivered the care. This meant that people were at risk of not receiving the care they required.

Medicines were managed safely. Staff took the time to explain to people about their medicines and where appropriate gave them choice about when to take them.

Appropriate recruitment checks were undertaken when new staff were employed to ensure they were suitable to work with people living in the service. Staff received regular supervision to support them in their

role.

People were protected from the risk of harm or abuse as staff members understood their responsibilities in safeguarding people. A contingency plan was in place to ensure people's care could continue safely in the event of an emergency.

People told us that the quality of food was good and that they were given choices at every meal. People were supported to maintain a healthy diet. However, staff were not always available to offer support and reassurance at mealtimes.

People were supported to maintain good health and had regular access to a range of healthcare professionals. People's needs were assessed prior to them moving into the service and care plans reflected this information.

People and their relatives spoke highly of the registered manager and staff team. Relatives told us they were able to visit at any time and were always made to feel welcome.

During this inspection we found a number of 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?

Requires Improvement

The service was not always safe.

Sufficient staff were not suitably deployed to meet people's needs and keep them safe.

Systems were not in place to ensure people were protected from the risk of infection.

Medicines were administered and managed safely.

People were safeguarded from the risk of abuse because staff understood their roles and responsibilities in protecting them.

Appropriate checks were undertaken when new staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not protected as disproportionate restraint was used.

People were supported by staff who had not received appropriate training to ensure they were competent to carry out their roles.

People were provided with food and drink which supported them to maintain a healthy diet.

People were supported to maintain good health and had regular access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always demonstrate the skills required to support people living with dementia.

People and their relatives told us that staff were friendly and

kind.

People were supported to maintain their personal appearance.

Relatives were kept informed of their family member's well-being.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with activities which supported them to maintain their hobbies and interests.

People's needs were assessed prior to moving into the service.

Care plans were in place which reflected people's needs and past histories.

Complaints were investigated and responded to. However, systems were not implemented to ensure the same concerns did not reoccur

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance audits were not routinely completed to ensure continuous improvement.

Records of the care people received were not completed by staff who had delivered the care.

Records were not maintained in a way which made them easy for staff to access.

Staff and relatives said the manager was approachable and responsive.

Ashbourne Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 13 January 2016 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

As part of the inspection we spoke with the registered manager, three staff members, four residents, two relatives and a visiting health care professional. The majority of people who lived at the home were living with dementia at different stages. Many of these people were unable to hold long conversations with us. Therefore we spent time observing the care and support people received in communal areas of the home.

We reviewed a range of records about people's care and how the service was managed. These included care records for six people and medicine administration record (MAR) sheets. We reviewed records relating to the management of the service. These included staff training, support and employment records for three staff members, quality assurance reports, policies and procedures, menus and accident and incident reports.

The service was last inspected on 1 March 2014 where it was found to be non-compliant in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, 'Respecting and involving people who use the service'. A responsive follow-up inspection took place on 18 August 2014 where we

found that issues identified had been addressed by the registered provider.

Requires Improvement

Is the service safe?

Our findings

We asked relatives whether they felt there were enough staff at the service. One told us, "Occasionally they are short but normally it's adequate. You can usually find someone if you need to. The residents are safe. Even in the late evening there is someone around." Another said, "I visit unannounced and have never seen anything untoward."

Despite these comments we found that sufficient staff were not always deployed to meet people's needs. The registered manager told us that staffing levels consisted of two care staff during the day and one staff member at night to cover both floors, with an additional sleep- in person on site. Separate kitchen and laundry staff were not employed, with care staff undertaking kitchen and laundry duties. A cleaner worked three times a week, but care staff undertook cleaning tasks when the cleaner was not on shift. The registered manager told us that they worked long hours at the service and would help to support people when required. We were shown evidence that staffing levels were decided based on the needs of people and that a monitoring tool was used to assess the staffing levels required. However, this tool did not take into account the additional responsibilities staff undertook in the kitchen and laundry.

During our inspection people received care at the times they preferred. However, our observations confirmed that people who had been assessed as being at high risk of falls were left unattended by staff. For example, there were no staff routinely based in the lounge area to support people. During the morning a staff member cleaned a spillage in the lounge which left the floor wet and slippery. A wet floor sign was placed in the lounge to alert people. The staff member then left the room for 15 minutes during which time one person who was assessed as being at high risk of falls went to walk across the wet floor. We intervened to ensure the person could safely walk around the area. The person's care file stated, 'supervise whilst mobilising and engage in activities to distract.' We observed the person was not supervised by staff throughout the day which meant they were placed at risk.

One member of staff confirmed that at times staffing levels impacted on the time they spent with people. They said, "A typical shift I come in just before eight for handover then bring those who want to into the dining room and give cereals, toast, eggs if they want. Then take them in the lounge, clean the dining room and kitchen. You always get interrupted. Then tea and biscuits at 11. Then start cooking lunch. It takes quite a while, cooking, helping some people and cleaning up."

Our observations during the inspection confirmed that staff spent time completing kitchen and domestic duties with meant staff were not always available to offer reassurance and guidance to people. We observed lunch in the dining room. Staff brought people's meals to them and then left the room. One staff member was busy in the kitchen and a second staff member was taking meals to people who had chosen to eat in their room. The dining room was silent during the meal and staff did not return until most people had finished eating their main course. A visiting relative supported their family member with their meal. Although other people were able to eat without support two people appeared anxious about how to start eating their food and there was no staff present to guide them. One person was whispering that they did not know why they were there and was looking around for reassurance. When people had finished their meal a staff

member came to ask if they had enjoyed it. The atmosphere changed quickly, people smiled, engaged with the staff member and began talking to each other.

Staff worked long hours and the number of hours worked was not monitored. Documentation regarding staffing showed that one staff member had worked every day for the past two months without having a day off. The registered manager told us they had not realised this was the case.

Failing to ensure that sufficient numbers of staff were deployed in the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of infection. There was a strong smell of urine in one of the corridors. In one person's room adjacent to the corridor the smell was extremely strong. The mattress and carpeting in the room was badly stained and the flooring in the en-suite was not sealed around the edges which posed an infection control risk to the person. The registered manager was unable to produce cleaning schedules to demonstrate how this was being addressed.

Safe procedures were not followed in relation to infection control. There were two mops and buckets in the laundry room which the registered manager confirmed were the only ones available in the home. The mop heads were in the buckets as storage facilities were not in place that allowed for appropriate cleaning and drying of them. There was no guidance available to staff regarding which mops should be used to clean specific areas, such as the toilets and bathrooms. Two yellow bags containing clinical waste were on the ground outside a side door of the premises. The registered manager showed us there was safe storage for clinical waste but was unable to say why this had not been used on this occasion.

Soiled washing was being stored next to clean laundry which posed a risk of cross infection to people. The registered manager told us that red bags were used to ensure safe cleaning of soiled laundry. However, after checking the registered manager confirmed none were available in the home for use. Stock was ordered during the inspection and we were assured they would be delivered the following day. The provider was not following recommended guidance in protecting people from the risk of infection.

The lack of effective infection control measures in place to protect people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood their responsibilities in safeguarding people from harm or abuse. The home had an up to date safeguarding policy in place and records showed that staff had completed safeguarding training. Staff were able to describe the action they should take if they thought someone was at risk or being harmed or abused. They told us, "I would go the manager first. I have phone numbers for whistle blowing if needed. I could go to social services."

A record of accidents was in place along with a monthly analysis completed by the registered manager. This ensured accidents were monitored and action taken to avoid reoccurrence. A member of staff was able to explain safe procedures that should be followed in the event that a person had an accident or sustained an injury. They said, "Look for signs that they might be injured even if you can see for example are they dizzy or feeling sick, are their eyes focused. Call the manager. If in any doubt call an ambulance. We complete an accident record and also record in the person's daily progress notes."

Risks to people had been identified. Risk assessments were in people's care records covering areas such as moving and handling, skin integrity including pressure sore risk assessments, malnutrition and mobility. Most risk assessments viewed showed that risks had been correctly identified, control measures were in

place and reviews had been completed in a timely manner. For example, one person assessed as being at high risk of malnutrition had been referred to the GP. Supplements had been prescribed and the person's weight remained stable.

Good medicines management processes were followed. People's medicines records were up to date which meant staff would know when people had received their medicines. Each person had a medication administration record (MAR) which stated what medicines they had been prescribed and when they should be taken. MAR's included people's photographs and there was a signature list to show which staff were trained to give medicines. We found no signature gaps in relation to people's MAR's which meant people had been given their medicines when they required them. Where someone had refused their medicines or it was not required this was clearly recorded.

The medicines trolley was locked at all times between use and medicines were stored at the correct temperature. There was documented evidence of destroyed and returned medicines as well as stock checks undertaken. Staff had a medicine policy providing guidance on the safe administration, handling, keeping, dispensing and recording of medicines.

Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. Staff files contained a photograph, interview records, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if a prospective staff have a criminal record or are barred from working with people who use care and support services.

Checks on the environment had been completed to ensure it was safe for people. These included safety checks on small portable electrical items, hot water, legionella, and fire safety equipment. Personal emergency evacuation plans were in place for each person that would help staff to know what support people would need in the event of a fire. An evacuation chair was located on the first floor of the home to assist people to leave the building if required. There was an emergency continuity plan in place that considered actions that would need to be taken in the event of emergencies that included fire, flood, power failure and loss of communication systems.

Equipment was available to ensure that people were moved safely when needed. Records were in place that confirmed that the hoist and sling were checked on a regular basis and were fit and safe for use. The registered manager informed us that no one at the home currently required assistance to move using this equipment.

Requires Improvement

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).

People were deprived of their liberty without the necessary safeguards being in place. One person's care files stated that they may leave their room at night and were at risk of falling down the stairs. The person's care plan stated their bedroom door should be locked to prevent this from happening. A staff member who regularly worked at night confirmed this was the case. They told us, "We lock door when (name) gets into bed, (name) sometimes tries to come out. We go in when we hear them at the door and encourage back to bed. Sometimes (name) won't listen, we come out and lock the door." The person's care file said a family member had given permission for the door to be locked, this was dated July 2013.

The staff member told us that another person was sometimes locked in their room at night. They said, "In the evenings if they're confused we lock the door, if they're grumpy and trying to come out we lock the door. They'll try to open the door; we go back and encourage them back to bed." There was no record with the persons care file that this practice was taking place although the registered manager told us that the person's relative had given permission for this to happen.

The registered manager said they had told staff members this practice should no longer happen. They were unable to provide evidence of this and care plans had not been changed to ensure staff had this information. Capacity assessments were not completed regarding this practice and no records were available to show that best interest meetings had been held or that less restrictive options to keep people safe had been considered. DoLS applications had been submitted to the local authority for both people. However, neither referred to the individuals being locked in their rooms at night. This meant the local authority did not have comprehensive information to enable them to correctly prioritise the applications and both people were still waiting for their applications to be processed. Following our inspection we alerted the local authority safeguarding team of our concerns regarding these practices.

There was a hook and key above people's bedroom doors and we observed a staff member locking people's doors when they had gone to sit in the lounge. The staff member told us this was done to prevent people going back into their rooms during the day without staff being aware. They told us they would unlock the door if the person wished to return to their room. This information was not documented in the DoLS applications we viewed.

All exit doors to the home were locked, including the front door. The registered manager told us that one person was able to leave the home independently and we observed this to be the case during our inspection. The registered manager told us, "I have done lots of DoLS applications for this but only one has been returned." We reviewed the applications made and found that applications had not been submitted for all people subject to these restrictions who had been assessed as not having capacity.

The use of disproportionate restraint was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that one person had their medicines administered covertly (administration of medicines in a disguised form) as at times they refused to take their medicines. We looked at this person's records and found that a mental capacity assessment was in place for 'assistance with personal care, treatment and administration of medication'. The assessment included evidence of why medicines needed to be given covertly, alternatives that had been explored, and that a medical practitioner and the person's family had been involved in decision making to ensure it was in the person's best interests. The assessment also included evidence that the MCA Code of Conduct had been followed in relation to assessing the person's abilities to retain information.

During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff asked people for consent before assisting them to move and to eat.

People may not receive safe, appropriate care as staff had not received training to meet people's needs. Systems were not in place to ensure that staff training was monitored effectively. The registered manager told us the system they had in place to monitor training was not up to date and they were unable to tell us when this information had last been reviewed. Discussions with staff, examination of records evidenced not all staff had received sufficient training which was reflected in their practice. We looked at the individual training records for the three care staff who were on duty during our inspection. One staff members file did not contain evidence that all mandatory training or training specific to the needs of the people living at the home had been completed. The staff member had been employed at the service since 2014. The staff member was unable to demonstrate their understanding of how to support people living with dementia. Staff had not received regular infection control training. Two of the three staff on duty at the time of inspection had completed this training, one in 2005 and another in 2013.

Failing to ensure that staff receive appropriate training to carry out their role was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence that two staff members had received training in safeguarding, first aid, moving and handling, MCA and DoLS, food hygiene and medicines. They had also completed training specific to the needs of people who lived at the home which included dementia awareness, continence care, diabetes and palliative care. When asked one staff member how they supported people living with dementia they were able to demonstrate their learning. They told us, "We still give choices and get to know their preferences by observing if they cannot tell us, we also find out about people from families."

Staff told us that they felt fully supported by the registered manager and that they received regular supervision and training. A member of staff confirmed they received an induction when they commenced employment. They said, "I did induction for five days then started to do work." The staff member confirmed that they were allocated a senior member of staff who they shadowed before starting work independently. Staff files evidenced that they received supervision and an annual appraisal.

Consideration had not been given to the environment and people living with dementia. Some people's bedroom doors had a picture to help them orientate but these were small and of poor quality. There was a large faced clock in the hallway and a date and weather board to help orientate people living with dementia. However, a noticeboard in the dining room had the incorrect date and year displayed. Part of the hallway on the first floor from people's rooms had an incline. No efforts had been made to differentiate this in order to help people.

We recommend the provider explores ways in which the environment can be adapted to meet the needs of people living with dementia.

People were provided with food and drink which supported them to maintain a healthy diet. We asked one staff member how people were given a choice at mealtimes they said, "I generally look what's in and give them a choice from that. Some people don't understand for example the difference between chicken and liver but I know who doesn't like liver so use my discretion." Before they started cooking we saw the staff member offered people a choice between two options for the lunchtime meal. There was no written or pictorial menu available and people were not shown the meals once they had been prepared to help them choose. Portion size was good and people responded positively when asked if they had enjoyed their meal. Most people told us they were happy with the meals provided. A relative told us, "The meals seem fine to me. It's not five stars but it's okay. I've had meals here and its fine."

A staff member was able to explain people's preferences in relation to drinks and snacks and we observed that these were provided. For example, one person was given biscuits that staff had broken into very small pieces. They explained that the person had no difficulties swallowing but that if given a whole biscuit the person would not eat it.

People were supported to stay healthy. This included calling the doctor as required and having access to chiropody, community psychiatric nurses and district nurses. A member of staff explained how they helped ensure people managed their health. They said, "I make sure they are safe, warm, plenty of fluids and right foods. If they don't seem well call the GP." People's weight was regularly monitored and action was taken promptly to contact the GP if significant changes occurred.

A visiting healthcare professional told us they felt people were supported with their healthcare needs. They told us that the referrals they received from the service were made in a timely manner and were always appropriate. They said that when instructions were left for care staff these were followed and they felt the registered manager was responsive to people's needs.

Action was taken when changes occurred in people's health. For example, we heard the registered manager requesting a GP to visit two people at the home as staff had noticed changes in their condition and behaviour. During our inspection the registered manager was observed checking on these people to make sure they had not deteriorated further.

Requires Improvement

Is the service caring?

Our findings

Relatives we spoke to said the service was caring. One relative said, "Staff have done everything to help (family member) to flourish." Another relative told us, "It's not the Ritz but they get good care. I've no complaints." When asked if they were happy with the care they received one person said, "Happy here."

Staff did not always demonstrate the skills to communicate effectively with people living with dementia. One staff member, due to language difficulties was unable to understand and respond to all of our questions. This meant that the staff member may not be able to understand or respond to people's needs or wishes. We observed that when talking to people the staff member sat on the arm of their chair rather than sitting at the same level as the person and making eye contact. This resulted in people having to look up or not engaging at all. The staff member asked one person if they would like to play with a soft ball. They did not wait for the person to respond before throwing the ball. The person said, "No", indicating they did not wish to participate and appeared confused when the ball landed on them.

We recommend that the provider ensures staff have the skills to communicate effectively with people living with dementia.

We observed other examples of staff interacting positively with people and the atmosphere in the service was calm and relaxed. When walking past people staff stopped to make conversation and share jokes. Staff supported people in a kind and sensitive way, ensuring their wellbeing and comfort when providing their care. We observed people responding positively to staff by sitting up, smiling and responding to conversations. We saw staff talking to people about their family members and their past occupations which showed they knew people well.

Attention had been given to people's personal appearance. Gentlemen were freshly shaven and ladies hair had been brushed. People were wearing colour co-ordinated clothing appropriate to the season and non-slip footwear. Where people wore glasses these were clean and some people had watches that had been set to the correct time.

One staff member we spoke to was able to explain how they promoted people's privacy and dignity. They said, "Always cover body up as much as possible if helping to wash. So if helping with bottom half cover the top. Don't let others in the room." They told us they believed it was important to treat people with respect, "Always knock on doors even if the person is not able to answer. Always ask permission before doing anything. Always think is this how I want my mum or dad to be treated." During the inspection we observed staff members knocked at people's doors before entering.

Choices around people's daily routines were respected. People told us that they were able to get up and go to bed at a time that suited them and this was confirmed during our observations on the day of inspection. One person was sat in a chair in the hall at lunchtime. A staff member gently encouraged them to move into the dining room. When the person refused to move they brought a table to the person so they could remain there to eat their lunch which they appeared happy with.

There was good communication between the home and people's relatives. One staff member told us, "We invite families to talk to us and vice versa. We keep families informed of everything, if unwell, fall, doctors' visits, everything." Relatives confirmed this. Relatives told us they were always made to feel welcome when visiting the service and there were no restrictions in place as to when they could visit.

Requires Improvement

Is the service responsive?

Our findings

People did not have access to activities which reflected their individual needs and preferences. The registered manager told us that there was no designated activity worker in place. An additional five hours of staffing was provided weekly to enable existing staff members to organise activities for people.

A list of activities was displayed in the dining room. The list was out of date and referred to activities which no longer happened. There were no designated days listed for specific activities and no pictorial prompts to help people understand what activities were happening when. The home used individual activity sheets for recording activities that had taken place and if people had participated in these. Those we viewed did not demonstrate activities were taking place on a regular basis. There was no evidence that staff took time to explore people's hobbies and interests prior to moving into the home or how people could be encouraged to maintain their interests.

Staff did not have time to sit and talk to people as they were focused on delivering care and completing domestic tasks. When we first arrived at the home five people were sitting in the lounge. The room was silent with no music and the television was not on. There were no staff present to chat with people and no one was engaging with others in the room. Everyone was sitting in chairs, their heads down as if asleep. After 15 minutes a member of staff came into the room with another person who lived at the home and put music on the stereo. The member of staff said to us, "That should wake everyone up." They then left the room for a further 10 minutes. During the late afternoon we saw that one staff member was completing domestic tasks and the second staff member was writing care notes in the hall. People in the lounge appeared to be sleeping and there was no staff member available. We observed that when a staff members did engage people in activities they responded positively. For example, a staff member sat and played cards with someone. The person appeared to enjoy this activity and spent time talking to the member of staff. Both were heard laughing and as a result another person sitting next to them also became animated, sitting up and smiling at them both.

Regarding activities one member of staff said, "They just don't want to go out. Families take those who are able out. We talk to people, play games, do silly dances if we have a spare 20 minutes. We do their nails. The hairdresser comes in." However, there was no evidence within individual activity sheets or care plans that showed people did not wish to go out. This meant people were at risk of being socially isolated.

The failure to provide activities which reflected people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had a comprehensive assessment of their health and care needs prior to moving to the home. Assessments showed that where appropriate people were involved in the assessment and their comments were recorded. These were completed in detail and highlighted people's preferences. There were clear links between assessment information and people's care plans.

Care plans contained information about personal histories and likes and dislikes. People's choices and

preferences were documented. A relative said, "They know what mum likes and they don't give her what she doesn't." Care plans gave guidance to staff on how people preferred to be supported and reminded staff that they should offer people choices.

Complaints were investigated and responded to in a timely manner. Information on what to do in the event of needing to make a complaint was displayed in the home. A record was in place of complaints received that included a record of actions taken to investigate the complaint and outcome. However, feedback from complaints was not reviewed and used to make improvements to the service. For example, three complaints had been received during 2015. Two included concerns about odours and one referred to concerns about staffing levels. A recent complaint had also highlighted the same issues. The concerns reflected our findings during our inspection and indicated that although the registered manager had taken action at the time of receiving a complaint they had not implemented systems to prevent these concerns recurring.

Inadequate

Is the service well-led?

Our findings

We asked people if they felt the service was well managed. One relative told us, "The manager and owner are both good and the staff are nice." A second relative said, "She (registered manager) always has a smile on her face. The atmosphere here is efficient but jolly."

We found the home was not well-led as a number of issues across the service were identified which showed the service needed to make improvements. The registered manager told us that due to staffing numbers they were required to spend time supporting people and staff. This meant that they were unable to find sufficient time to complete management tasks and address improvements which were needed.

Audits of the quality of the service were not completed regularly and action plans of improvements required were not recorded. Infection control audits were last completed in May 2015. We noted that areas identified as requiring improvement during our inspection were not recorded. A quality assurance assessment designed to be completed every six months had last been completed in April 2015.

The provider had commissioned an external consultant to identify areas of potential improvement in the quality of the service. The consultant had prepared an initial report in July 2015 and had returned on the day of our inspection to assess progress made and provide additional guidance. We saw the report addressed a number of the areas highlighted during our inspection including the monitoring and delivery of training, and infection control audits. The registered manager told us they had not time to address the recommendations made and had therefore requested on-

Staff were not given the opportunity to be involved in the running of the service as staff meetings were not held. The registered manager told us they used daily handovers with staff to pass on any relevant information to staff. However, no records of handover meetings were kept. Staff confirmed that handovers during shifts normally took place daily but were not recorded. This meant there was a potential that information was not consistently provided to all staff members. For example, the manager told us that staff had been informed that the practice of locking bedroom doors at night should stop. Staff confirmed that this was still happening.

There were no formal systems in place for involving people in how the service was run. A member of staff told us they had previously held a residents meeting. They said, "But they did not understand." The registered manager was unable to provide evidence on how people influenced how the service was run and managed.

The lack of effective systems to ensure good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to records not being completed accurately people were at risk of not receiving the care they required. Records of care given were being completed by staff who had not delivered the care. A staff member working in the afternoon was completing notes for care that had been provided by staff in the morning. One

person's daily notes stated that fluids and mouth care had been given. However, the fluid intake chart for the person stated they had not received any fluids since the previous day when they had refused. No mouth care had been recorded on the chart. The staff member who had completed the notes told us they had done so because they were sure the staff on duty would have provided the care the person needed. They told us it was normal practice to complete care notes for care provided by the morning shift. They said, "I normally have a handover when I come on shift but it was too busy today. We go through every person so I can write the notes from what they've told me." Following our discussion the staff member continued to write notes regarding people's care they had not been involved in. We spoke to the registered manager about our concerns. They said, "I would normally have completed the notes but have been too busy." This meant that staff working in the afternoon were not aware if people needed the care needed. No handover of information was witnessed during the inspection.

People's care records were not organised and not effective in providing quick access for staff. Care plans were reviewed regularly although any changes in people's care needs were written on an update sheet at the back of the original plan. Some care plans had originally been completed in 2013. This meant that staff were required to read updates for over two years to ensure they had the most up to date information regarding people's care needs and potential risks to their safety.

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

Feedback on the quality of the service from professionals and family members was sought. A survey of visiting professionals and relatives had recently been started in January 2016. Comments received at the time of the inspection were positive, particularly with regard to the responsiveness and manner of the registered manager.

Staff told us that the registered manager was approachable and supportive. One said, "The manager is brilliant. I really admire her. She is so supportive of families, residents and staff. She is here a lot. She is such a good teacher as well. She is also open to suggestions. She is just the life and soul of this place."

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to provide activities which reflected people's individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure systems were in place to protect people from the risk of infection control

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The use of disproportionate restraint.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to implement effective systems to ensure good governance. The registered provider had failed to keep accurate records of people's care.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had failed to ensure sufficient staff were deployed to meet people's needs.

The registered provider had failed to ensure that staff received appropriate training to carry out their role.