Care Quality Commission

Ashdown Care Limited

Ashdowne Care Centre

Inspection report

Orkney Mews, Pinnexmoor Road,
Tiverton,
Devon, EX16 6SJ
Tel: 01884 252527
Website: http://halcyon-care.co.uk

Date of inspection visit: 26 FEBRUARY AND 6 MARCH 2015
Date of publication: 15/05/2015

Ratings

Overall rating for this service	**Requires Improvement** 
Is the service safe?	**Requires Improvement** 
Is the service effective?	**Requires Improvement** 
Is the service caring?	**Good** 
Is the service responsive?	**Requires Improvement** 
Is the service well-led?	**Requires Improvement** 

Overall summary

We carried out an unannounced comprehensive inspection on 26 February 2015 and 6 March 2015. We had decided to bring forward a planned inspection because we received two alerts from the local authority safeguarding team regarding people at the home developing skin damage which could have been caused by poor care management and two concerns about the skills of the staff at the home.

Ashdowne Care Centre is registered to provide accommodation with nursing or personal care, for up to 60 people. The service is intended for older people, who may have needs due to dementia or other mental health needs. The home is divided into two units, Ashdowne and Pinnexmoor, with each area having its own staff team. The two units are joined by a link corridor. There were 53 people living at the home at the time of our inspection.

There was a registered manager. 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.'

Summary of findings

We last inspected the home in October 2014 to follow up actions taken by the provider following breaches in the regulations we found at an inspection in July 2014. At that inspection we found improvements had been made to people's care and welfare and the staffing at the home. This meant the service was meeting all the regulations inspected.

People received most of their prescribed medicines on time and in a safe way. However, some improvements were needed in management of topical creams and ointments.

People's needs were assessed but improvements were needed to ensure all care plans and risk assessments were regularly reviewed so staff were provided with the detailed information they needed to deliver consistent and appropriate care. People and their representatives were not actively being involved with making decisions about their care but relatives were being kept informed of any changes and concerns.

Where people did not have the capacity to consent or make decisions, the provider had not acted in accordance the Mental Capacity Act (2005) and Deprivation of Liberty safeguards. There were no mental capacity assessments for people who lacked capacity. This meant staff did not have information to assist people to make decisions for themselves. Staff were seeking consent from relatives for people who they assumed lacked capacity. There was no records of 'best interest' decision making to show how people, relatives and other professionals were consulted and involved in decision making about people's care and treatment.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Seven applications had been made to deprive people of their liberty and the registered manager was prioritising the assessment of other people at the home to consider whether any further applications were required.

People were at risk of being socially isolated because they were not being given the choice to come out of their rooms and use the communal areas at the home. Activities were provided at the home but there were long periods of time when meaningful activities were not happening and people isolated in their rooms were not able to access the activities at the home.

Improvements in staff training were needed to ensure staff were supported to acquire and maintain skills and knowledge to meet people's needs effectively and safely. The majority of staff had not received training in MCA and DoLS. Staff did not receive formal supervision and appraisal so they did not have the opportunity to express their views and concerns and to identify their training needs. Staff recruitment processes were safe and there were enough staff employed to meet the needs of people in the home.

Quality assurance and audit processes were in place to help monitor the quality of the service provided. The provider had an operations manager who visited the home and monitored the quality of service to identify, assess and manage risks relating to people's health, welfare and safety. However they had not recognised or dealt with all of the identified shortfalls found at this inspection.

Improvements were required to ensure systems and processes were in place to protect people's rights, to ensure they were supported by staff who had received appropriate training and supervision and to make care more personalised and accurate to people's individual needs. The provider did not regularly seek the views of people using the service and staff. Relatives and representatives and health professionals were asked annually to complete a quality assurance questionnaire for their views on the service.

The premises were well managed to keep people safe. At this inspection staff were aware of signs of abuse and knew how to report concerns and were confident these would be investigated. Staff working at the home knew people's needs and preferences well and people and relatives said staff were caring and kind. There were friendly and respectful interactions between staff and people. People were supported to have suitable and sufficient food and drink.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Medicines were managed safely. However improvements were needed in the management of prescribed topical creams and ointments.

People were supported by having enough staff on duty to meet their needs.

Individual risk assessments had been completed to identify health risks. Individual evacuation plans were in place to protect people.

The premises were well managed to keep people safe.

Staff were aware of signs of abuse and knew how to report concerns and were confident these would be investigated.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not have all the knowledge and skills they needed to support people's care and treatment needs. Staff had not received effective inductions, regular supervision and appraisals and had not had the opportunity to develop their training needs.

People did not consistently experience care, treatment and support that met their needs and protected their rights. This was because staff did not understand and were not acting in accordance with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

People were supported to eat and drink and had adequate nutrition to meet their needs.

People living at the home did not always have prompt access to healthcare services because staff did not always have a clear understanding of their responsibilities with regards to people under the care of the district nurse team. People under the direct care of the home had prompt referrals to specialist healthcare services.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and their privacy and dignity were respected. Staff were caring, friendly and spoke pleasantly to people. They knew people well, visitors were encouraged and welcomed.

However people and their representatives were not actively involved in making decisions about the care, treatment and support they received.

Summary of findings

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People were not consistently receiving support that was responsive to their needs. People's care needs were not always regularly reviewed, assessed and recorded. People could not be assured there care needs would be recognised promptly and might not receive care when they needed it.

People were at risk of social isolation by being nursed in their bedrooms and were not being actively supported to take part in social activities.

People were aware of the complaints procedure and complaints received were addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The registered manager understood their responsibilities, and had support from the provider. However due to covering nursing shifts they had not been able to deliver their managerial responsibilities.

Although systems were in place to provide quality checks, these had not picked up on all areas of concern.

Staff did not receive feedback from registered manager in a constructive and motivating way that meant they knew what action they needed to take. The registered manager was not challenging poor practice and even though identifying concerns not taking robust actions to address and then follow up.

The provider did not make sure staff are supported. There were no systems to ensure staff received regular supervision and appraisals. No effective system to monitor staff training needs and ensure all staff have received training and effective inductions.

People were not actively involved in developing the service. There were no meetings with people and their families either on a one to one or as a group to find out their views.

There was no effective system to monitor and review people's care records were accurate, regularly reviewed and reflective of people's needs.

Robust records and data management systems were not in place. Fluid and monitoring charts were not always accurately completed. Records for the safe running of the service were not promptly accessible when requested

Ashdowne Care Centre

Detailed findings

Background to this inspection

2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We reviewed information we had about the service such as, 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 information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We contacted commissioners of the service and external health professionals to obtain feedback about the care provided.

On the first day of the inspection one inspector and expert by experience spent time on the Pinnexmoor unit at the home. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service, they had experience of services for older people with dementia. On the second day of our inspection two inspectors spent time on both units and looked at care records and quality monitoring at the home.

We met most of the people who lived at the home and received feedback from three people using the service and nine relatives. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not talk with us.

We spoke with 12 staff, which included nurses, care and support staff, the provider, and registered manager and the provider's operations manager. We looked in detail at the care provided to five people which included looking at their care records. We looked at four staff records and at staff training, supervision and appraisal records. We also looked at a range of quality monitoring information.

Requires Improvement

Is the service safe?

Our findings

People who were able to tell us, said they felt safe. Comments included, "I like it here and wouldn't want to go anywhere else" and "They look after me very well". Visitors said they felt the people they visited were safe. Comments included, "I feel she is safe, staff are kind generally, some better than others." "They do their best to make her comfortable" and "It's great here, the staff are wonderful".

People received their medicines safely and on time with the exception of prescribed topical creams. People were given their medicines by the nurses on duty who were responsible for administering medicines; they demonstrated a good knowledge of people's medicines. However there was no oversight by the nurses to ensure people had their prescribed topical creams safely administered. Medication records and cream charts did not include clear guidance for staff about the application and frequency for creams to be applied. Records of creams applied were not always completed. This meant they could not be sure if prescribed creams had been applied as prescribed or whether staff had forgotten to record their use. The operations manager was aware this was an area for improvement. They said they were working to improve the guidance and would implement measures to monitor cream charts and make sure they were completed accurately each day.

Medicines at the home were locked away in accordance with current legislation and medicines which required refrigeration were stored at the recommended temperature. The pharmacist supplying medicines to the home had undertaken a review in October 2014. Records showed the home had actioned their recommendations which included updating people's photographs so a current likeness was available to guide staff.

Staff were knowledgeable about how to recognise signs of potential abuse and said they were confident any concerns raised with senior staff would be dealt with. However records were not clear whether all staff at the home had received training in safeguarding and four staff could not confirm they had received training and three said they had not. The registered manager said they were sure all staff had undertaken safeguarding training but could not evidence they had. The registered manager keeps the Care Quality Commission informed of any safeguarding concerns at the home by sending required notifications.

Staff said there were enough staff to provide people with the support they needed and to keep people safe. However the provider had experienced difficulty recruiting registered nurses at the home, which had been resolved at the time of our inspection. During that time the registered manager had spent a lot of time trying to allocate nursing duties and when this was not possible undertaken nursing shifts themselves. They had needed to make a decision that there were times when night shifts would be covered by one nurse instead of the usual two. To protect people they had increased the amount of care staff on duty, put into place emergency procedures and an on call system for these occasions. Nurses employed at the home had also undertaken a lot of additional duties to cover these shortages. This had caused a strain on systems at the home as the registered manager and nurses were firefighting which had impacted on staff receiving formal support and care documentation not being completed and reviewed. The registered manager said they were confident now they had a full complement of trained nurses they would be able to review people's care records and implement formal support for staff.

A couple of staff commented that there were times during the day when they were stretched and additional staff would be beneficial. Comments included, "We could do with more carers in the morning" and "There are usually enough staff. It depends on which staff are working". Visitors said they were happy there always seemed to be enough staff. One commented, "They have increased the staff a little, and the staff seem happy, I don't hear them moaning". During our visit staff were available and the few call bells we heard were answered quickly. The staff rotas for three weeks from 23 February to 15 March 2015 confirmed shifts had been covered to maintain the staffing levels described by the registered manager. This included having two nurses allocated each night to the cover the night duty.

Safe recruitment processes were in place, and the required checks were undertaken prior to staff starting work. This included completion of a disclosure and barring service check to help ensure staff were safe to work with vulnerable adults and two appropriate references being obtained.

Communal areas of the home and people's rooms were clean with no unpleasant odours. One visitor said, I am

Requires Improvement

Is the service safe?

quite happy, it is lovely here for (my relative), lovely and clean. Staff had access to appropriate cleaning materials and equipment. Staff had access to personal protective equipment (PPE's) such as gloves and aprons.

The environment was safe and secure to people who used the service and staff. There were arrangements in place to manage the premises and equipment. A full time maintenance person undertook regular checks, which included, checking water temperatures, window restrictors, emergency lighting and wheelchairs. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person. Fire checks and drills were carried out weekly in accordance with fire regulations and regular testing of electrical equipment was carried out with the next test due in June 2015. There was evidence of regular servicing and testing of moving and handling equipment. The provider told us in their PIR they were intending to continue with on-going refurbishment, which included resurfacing of corridor areas, upgrading of furniture and furnishings and Installation of new call bell alarm system linking between the two units for emergency situations.

There were individual personal evacuation plans which took account of people's mobility and communication needs. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely. Accidents and incidents were reported in accordance with the organisation's policies and procedures.

Requires Improvement

Is the service effective?

Our findings

Staff had day to day support but did not have formal supervision and appraisals. Records showed no staff had received appraisals in the last twelve months and there were only four supervision records which had been completed in February 2015 since our last inspection. Staff said they had not received formal supervision but were happy they were supported on a day to day basis by the nurses on duty but did not have the opportunity to formally discuss their development. The registered manager said there were plans to delegate supervisions and appraisals to unit leads when they were in place, although she would still oversee the nurses and some ancillary staff appraisals and supervisions. This showed there was not a system in place to effectively support staff in relation to their responsibilities and development.

We could not be assured that all staff had the necessary skills required because there was no effective system to ensure training needs were assessed. Inductions were poorly documented and it was not clear how effective they had been for some staff. All of the staff files we looked at did not contain any induction training records. A new staff member was on induction during our inspection and was being supported by a more experienced member of staff. The registered manager said they had guided the new member of staff regarding how to support somebody with their food while in bed. However the new member of staff whose first language was not English was seen supporting a person not following the registered managers guidance. This meant the registered manager had not ensured the induction process was suitable and tailored around the staff member's needs.

The registered manager had not monitored the staff training. They were aware some staff had training gaps but due to time restraints had not required scheduled training. They had not assessed individual staffs' knowledge to make sure training covered the right areas to meet people's needs. The training matrix was incomplete and did not identify all of the staff who worked at the home. Staff folders contained some certificates and others had none. This meant the service could not clearly identify what training had been undertaken at the home. Some staff said they had received very little training at the home. Two staff members who had worked at the home for over six months said they had undertaken three days shadowing as part of their induction and had received no further training at the home and relied on training they had received in their previous roles. Clinical skills of the nurses had not been assessed and therefore no implementation of required training to ensure they had the required skills to meet the needs of people's living at the home. Health professionals said they had concerns regarding the level of experience and understanding of some nurses. Comments included, "Staff knowledge and ability is very varied and the training very basic. However at the inspection people were receiving appropriate care and staff demonstrated competence and the appropriate skills needed to support peoples care and treatment. For example, staff using specialist equipment to move people did so in a skilled manner. Following the inspection the registered manager sent us an action plan telling us the training matrix was being updated, were implementing further training and going to review the training at the home on a monthly basis. The registered manager had also arranged for nurses at the home to undertake syringe driver training (a devise used to administer pain relief in a controlled dose to ensure people are pain free) and the District nurse team manager had agreed to support nurses in the use of syringe drivers.

The provider was not ensuring staff were receiving appropriate support, training and professional development, supervision and appraisal. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and associated Codes of practice. Staff demonstrated an understanding of the principles of the MCA and DoLS. They were offering people choices about day to day decisions. For example, whether they wanted a cup of tea or coffee. One staff member said "If people are asleep we leave them, some mornings there are a lot of people up, they get the choice." If people want to stay in bed they can". Staff said they had not undertaken training in the MCA; however the registered manager said some staff had received training. The provider could not confirm how many staff had undertaken MCA training because the training matrix was not accurate. Following the inspection the registered manager sent us an action plan telling us they had scheduled online MCA training for the nurses at the home.

Requires Improvement

Is the service effective?

People who lacked mental capacity to take particular decisions were not protected. The MCA sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. People who were assumed not to have capacity had not had their mental capacity assessed and best interest decisions had not been made in accordance with the Act. The staff had assumed people did not have capacity and had requested their next of kin sign documents on their behalf. This included consenting to access to the person's care and health records and to be photographed, without ensuring this was in the person's best interest and what they would have wanted.

The provider was not gaining consent from the relevant people and were not acting in accordance with The Mental Capacity Act 2005. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our first visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) application. This is where an application can be made to lawfully deprive a person of their liberties where it is deemed to be in their best interests or for their own safety. The registered manager was aware of the Supreme Court judgement in March 2014 and intended to make applications to the local authority DoLS team. On the second day of our visit the registered manager said they had prioritised the applications and had submitted seven and would be assessing all of the people at the home and submitting applications where required.

Before the inspection we had been made aware that two people at the home had developed skin damage. As an outcome of these incidents the registered manager, operations manager and staff had worked closely with the local district nurse team and commissioners and had put into place monitoring of pressure relieving equipment, new pressure relieving equipment and systems for staff to be more alert in looking for the signs of pressure damage. At the inspection there were no further incidents of people developing skin damage. People's skin was being assessed and people with skin damage were receiving appropriate care and support.

Handovers at the home were not consistent regarding the information being handed over to staff. Staff said it depended on the nurses on duty how much information they were told. They relied on word of mouth to guide care staff. There was a daily handover sheet used by the nurses, however these were inconsistently completed and the majority contained only a small amount of information. This meant staff were not always receiving up to date information about peoples changing needs to enable them to provide appropriate support.

The home supported some people without a nursing need and these people's health needs were overseen by the local district nurse team. We found two examples where the nurses at the home did not have a clear understanding of their role regarding these people and referrals to health professionals had not being made in a timely way. For example, the district nurse team had not been promptly alerted regarding a person whose skin was showing signs of breakdown and a person requiring pain relief. However people under the direct care of the nurses at the home were being referred appropriately to health services. For example, referrals had been made to the speech and language team (SALT), opticians, chiropodists and occupational therapists. One visitor said, "I've no complaints, she had a bit of a chill and (the registered manager) rang me straight up and got the doctor for her".

Guidance from outside professionals was acted upon but not regularly reviewed to ensure it was required. For example, one person was not receiving baths because the district nurse team had advised due to a health need it would not be appropriate. However the person's health need had improved and they were still not receiving baths. Care staff said the person enjoyed having a bath but they had been told they couldn't bath them due to dressings in place. The district nurse confirmed they had advised the home not to bath the person over six months ago, however a bath would be beneficial for this persons current health need.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they generally enjoyed the food. One person commented, "The dinner was very nice". A visitor said, "I come in six or seven days a week and help with her food as it helps them too. She has a pureed diet and there's no problems at all".

Requires Improvement

Is the service effective?

People's nutritional screening was undertaken using a Malnutrition Universal Screening Tool

(MUST) on admission and reviewed monthly by the nurses. This assessment identified people who were at risk from dehydration or poor nutrition. However people's weight was not being routinely monitored and recorded as part of this risk assessment. Some food and fluid charts were not consistently completed which meant people's intake was not always being properly monitored

Referrals had been made to people's GPs and the Speech and Language Therapist (SALT) who provided assessment, advice and guidance in relation to people's swallowing. The SALT had made recommendations to support one person to swallow safely, staff were following these recommendations. For example, staff prepared thickened fluids as directed and had a good understanding of the consistency and pureed foods were given as prescribed by the SALT. Pureed meals were prepared in a way that was appealing to the person and each portion was presented separately on the plate.

We observed the lunchtime meals on both units. People who needed assistance were supported with their meals.

Staff chatted to the people they were assisting and told them what they were having to eat. They encouraged them to eat and took time without rushing to ensure they ate sufficient .

The home had a four week menu and gave two main meal options. On one day of our visit these were cornbeef and bean pie or fish fingers and chips. A staff member said each afternoon people were given the choice of menu for the following day. The care staff had a sheet guiding them of people's choices and could tell us about the different meals provided. For example, fork mashable option, puree option and vegetarian.

However on the Pinnexmoor unit where people might have difficulty remembering their meal choice, there were no visual prompts only a small white board which was very difficult to read reminding people of what the mealtime option was. People sat at the tables waiting for their lunch could not tell us what the meal option was and yet the activity person had arranged a special treat of fish and chips from the local fish and chip shop.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by staff who knew each person well and understood their likes, dislikes and any preferences. One person said, "I've been here years…oh yes it's very good here." another commented, "The people are very, very nice here." A visitor commented on the friendliness of the staff and commented "I like to laugh and joke with them…they're great." Another said, "There has been a big difference here over the past few weeks, the new staff are very caring".

People were treated with affection and patience by staff. On the Pinnexmoor unit staff were skilled in their approach and demonstrated an understanding of how to speak appropriately to people with dementia. Staff were consistently polite and gentle and people responded well to this approach. For example, when staff were supporting a person to move to the dining table, they used the person's name, rubbed their hands gently to reassure them, took time to explain what was happening and waited patiently.

There was a calm atmosphere at the home and each person at the home looked well cared for and was dressed appropriately. People who could on the Pinnexmoor unit, were free to walk about in the communal areas and out into the enclosed garden. They reflected the caring nature of the staff and were walking around holding hands and appropriately cuddling friends. They supported each other gently although their communication was poor.

Staff were positive about working at the home. Comments included, "I love it here and I love the people" and another who had worked at the home for many years said "I love it here it is a nice place to work".

Relatives who had people at the home who lacked capacity, felt they were consulted about their relatives care and told of concerns but only one had seen the person's care plans because they had requested to look at them. Comments included, "they keep me informed" and "I ask lots of questions so I know what is happening".

There were no set visiting times at the home which enable relatives and friends to visit at times that suited them and the people they visit. For example, two visitors came most days at lunchtime so they could support the person they visit with their meal. One commented, "It is very important for me to feel involved and useful".

Information about people was treated in a confidential way. All personal information was kept in either a locked office or in a locked filing cabinet to make sure it remained confidential. When staff wished to discuss a confidential matter they did not do so in front of other people who lived at the home. Bedroom and bathroom doors were kept closed when care was being provided. People who could tell us, said their privacy was respected. Staff were respectful and knocked on people's bedroom doors and waited to be invited in before opening the door.

All rooms at the home except one were being used for single occupancy, even though 12 were registered for double occupancy. The provider had just completed some refurbishment on the Pinnexmoor unit which included the provision of six new bedrooms with ensuite facilities which had reduced the use of double occupancy at the home. Some people had personalised their bedroom with their possessions, such as pieces of furniture, pictures, photographs and ornaments. This gave these bedrooms a personal and homely feel.

At the time of our visit the home were supporting a person receiving end of life care. The persons care records had been reviewed and reflected the changes in the person's needs and gave staff direction about the care required.

Requires Improvement

Is the service responsive?

Our findings

Prior to coming to live at the home, each person had a pre admission assessment completed by the registered manager or a delegated nurse to confirm the home was able to meet their needs. These assessments were used to populate people's care plans and guide staff to meet people's needs.

Care plans had inconsistencies and people's changing care needs were not identified promptly and were not regularly reviewed. Three people's care records did not accurately reflect the care they were receiving. For example one person had recently been unwell which had caused them to be more confused. Staff had identified the person was unwell and a referral had been made the GP. However there were no changes made to the way this person was cared for and risk assessments and care plans were not reviewed and updated to ensure the required care was given. A second persons care records were conflicting and giving staff incorrect information. In one part of the care folder it identified that they were independent with a walking frame and in another part made reference to them needing a hoist to be transferred. The person's dietary requirements were conflicting, from eating independently to requiring full assistance and from having a fork mashable diet to requiring a soft diet. This person's care records had been reviewed by the second day of our visit following our discussions with the registered manager at the end of our first day.

Arrangements were not in place to make sure people and their families where appropriate were involved in making decisions and planning their own care. Visitors we spoke with said they had not been involved in developing and reviewing care plans. Comments included, "I have never seen a care plan, the care is very good, always niggles but I tell the nurse and they deal with it. I haven't been asked about reviews" and "Staff speak to us if there is a problem, we haven't been to a review" and "I haven't seen X's care plan, there was no initial review and none since". One person said, "Sometimes I ask for her folder, so I can see what has been written and I quiz them about things". This meant people and relatives had not been involved in the development and review of their care plans in a meaningful way. Instead, care records had been written and regularly reviewed by the nurses.

A relative had replied in the April 2014 survey carried out by the provider, "Maybe 2-3 weeks after admission, staff to have meeting with resident/relative to discuss care plans, problems or suggestions (more of a formal review)". This had not been added to the action plan following the survey. However the response from the same survey of relatives, friends and representatives, out of seven replies received, six responded they had been involved in planning the care required.

Staff demonstrated skills supporting people at the home who were living with dementia. New nurses at the home with mental health qualifications were leading by example and teaching staff how to skilfully meet people's individual day to day needs. For example, staff used a range of responses to a person who was constantly making requests, they remained patient and tried to engage the person in conversation with others at the home.

We asked people and visiting relatives about raising concerns and complaints. They all said they would be happy to raise concerns with senior staff and were confident they would be dealt with. Their comments included, "If I have a concern I go to (nurse), they are very good and always sort out things I raise. Another said "If I have something I would like to raise I speak to (nurse) because (nurse) is approachable, listens and is proactive". Two visitors said they had raised a concern regarding missing clothes, one visitor was happy the clothes had been found the other said some clothes had been found but they were still missing some. The registered manager showed us a form which staff could use to record concerns raised with them, there were no completed forms available for us to view.

People at the home were not protected from the risks of social isolation and loneliness and staff had not recognised the importance of social contact. An activities co-ordinator worked at the home and their time was spread over the two units. On the Pinnexmoor unit an activity sheet showed activities occurred in the afternoons from Monday to Thursday and on the day of our first visit it was hand therapy. However during the morning there were no attempts to engage people in meaningful activities other than the television. Staff were very caring and spent time sitting with people, stroking their hands, talking and reassuring them but there were no activities offered for example, jigsaw puzzles, crafts. One person said, "It is alright, I keep myself busy, it can be very quiet here

Requires Improvement

Is the service responsive?

though". One visitor said, "Activities, mum doesn't do a lot, there is not a lot for her to do, sometimes she sits to the table in the dining room, I don't know why she doesn't do it more often". Another visitor said, "I would like dad to sit out, he would like that". The operations manager said they were in the process of recruiting a second activity person, which would increase the activity provision on each unit.

On the second day of our visit we identified there were 27 people in their bedrooms at midday, with 16 of these people being nursed in bed. We asked the staff and the registered manager had these people made the decision to stay in their bedrooms or was it because of a health reason. They were able to tell us about some of the people who had made the choice to stay in their rooms and others who due to health needs required to be nursed in bed.

Following the inspection we requested further information from the registered manager to breakdown the reasons 16 people were being nursed in bed. The registered manager responded that upon reviewing people being nursed in bed and discussing with people their choice, 11 people were spending more time out of bed either in the lounge or in their bedroom and others were undergoing appropriate assessments and referrals to health professionals. This showed people's needs had not been properly reviewed prior to the inspection.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection the provider had experienced difficulty recruiting registered nurses. The registered manager said they had a full complement of nurses employed at the time of our inspection. However this had meant during the past six months the registered manager had undertaken a number of nursing shifts, which had meant other managerial duties, had been neglected. The registered manager said "There is light at the end of the tunnel it has been very short staffed here, it has been a real struggle, we are still not where we would like to be, just need time".

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC).The registered manager knew their responsibilities and had needed to prioritise these to deliver care safely at the home. The registered manager was supported by an operations manager who undertakes quality assurance visits and supports the registered manager. However during the past few months the provider had not recognised the pressures on the registered manager and how undertaking nursing shifts had impacted on the service. The operations manager said the provider did not use agency nurses at the home because they felt they would not know their systems and the needs of the people living at the home.

There was no formal system of hierarchy at the home other than the operations manager and registered manager. This meant the nurses were all working at the same level and the registered manager was not supported by nominated senior staff who would support them in their role or take responsibility for the management of the home in their absence. The Provider Information Return (PIR) recorded that they planned to appoint a deputy manager of the Pinnexmoor unit within the next year. However following our inspection an action plan was sent to us by the registered manager saying two nurses had been appointed as unit leads at the home to take on additional responsibilities which included undertaking staff supervisions/appraisals and an overview of care and care planning for each unit.

The provider is required by law to notify the Care Quality Commission of significant events such as deaths, and any allegations or instances of abuse. Notifications were reported appropriately to CQC.

The registered manger was not giving staff clear feedback about actions they needed to take in a constructive and motivating way. For example, the registered manager had identified concerns about the monitoring of people's weights and had implemented a system to identify and monitor people at risk. However staff had not been guided to use this system and the weight monitoring had not been completed. The registered manager said they were aware, people had not been weighed as requested and confirmed they had not taken any action to rectify this.

The registered manager was not challenging poor practice and even though identifying concerns had been noted, there was no robust actions to address and then follow up. Staff were not following the provider's uniform policy which was last reviewed in July 2013. This stated that staff should wear stud earrings, name badges and sensible shoes. Staff were wearing jeans, boots, no badges, multiple earrings and necklaces. A relative had recorded in response to the April 2014 survey, "I would like to see the staff wearing 'first name' badges. Nice for residents and relatives to know who they are talking to". An action plan had set an action for all staff to be provided with a badge by the end of August 2014. However we did not see staff wearing badges during our visits.

Staff and visitors to the home gave mixed feedback about the effectiveness of the registered manager to respond to suggestions and concerns. Staff said they would approach the registered manager but she was always busy so would go to one of the nurses. One staff member said they were not confident the registered manager would deal with their concerns. One visitor said, "The manager would probably deal with my concerns," another said, "I don't find the manager approachable".

The operations manager undertook quality assurance visits. The last two visits were in February 2015 and November 2014. These visits looked at areas such as, medicine management, environment, staffing and care records. Records showed during these visits they spoke with people, staff and visitors and set actions for the registered manager to complete. The February 2015 visit report identified staff training required, in the Mental Capacity Act, equality and diversity and safeguarding of vulnerable adults. They had also identified the training grid used at the home needed to be updated regarding staff changes. As a result an action had been set to update the staff changes by 23 March 2015.

Requires Improvement

Is the service well-led?

At the November 2014 visit the operations manager had looked at four people's care records and identified some areas of concern. These included a lack of an assessment of a person's pressure area on admission, a review of a person's risk of possible skin damage not taken place for over three months, a person's profile and risk of choking had not been completed. As a result of this an action plan had been generated to review these care records. The registered manager said the actions in the action report had been reviewed. Part of the operations managers' assessment of peoples care folders was to check people and their relative's involvement in their reviews. However there was no evidence this was being looked at and people and visitors said they had not been involved with the implementation and reviews of their care plans.

The registered manager confirmed there had been no accidents or incidents this year. However accidents and incident records from 2014 were detailed and had been analysed by the registered manager and actions taken. Falls were recorded separately and action plans had been put in place for falls in January 2015 but not February 2015. This meant there was a risk that lessons learned could be missed because of a prompt analysis was not undertaken to see if there were patterns or themes which could be avoided. For example, one person's care records recorded they had five falls in February 2015 which had not been analysed to assess if further falls could have been prevented.

People using the service were not offered the opportunity to make their views known and were not actively involved in developing the service. They were not given the opportunity to complete a satisfaction survey and there were no residents meetings for them to make their views known.

Staff were not requested to complete a questionnaire and the registered manager said staff meetings had been very difficult to arrange because of time restraints due to undertaking shifts. However the registered nurses were scheduled to attend a meeting at the home the first day of our visit which was subsequently cancelled, their last meeting had been in August 2014. The registered manager said they had recently had a care staff meeting but only four staff had attended and the minutes of the meeting had not been written yet.

The provider did have effective quality monitoring systems in place. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives, friend and representatives of people using the service were asked to complete an annual satisfaction questionnaire. The April 2014 survey had been sent to 12 representatives of people using the service and seven responded. Questions included, the quality of care provision, social activities, maintenance and knowledge of the complaints procedure. Overall the responses were positive but three people felt the activities were fair with two people not commenting and two responses said they did not know about the complaints procedure and who to complain to. There was a complaints policy in both reception areas at the home. People said concerns raised had been dealt with promptly and satisfactorily. The two complaints shown to us had been thoroughly investigated and recorded in line with the provider's policy.

Health professionals were also sent a quality assurance questionnaire in April 2014 so the provider could use the information gathered to improve quality across the service. Out of 12 surveys sent out only two responded. The two responses were mixed with one recording excellent to staff knowledge and care and the other rating these as fair.

People were at risk because accurate records about each person were not consistently maintained. We found gaps in people's food and fluid charts as well as in prescribed cream charts. We could not be assured from these records that people's care needs were being met. We found conflicting information in people's care folders and information which had not been archived which put people at risk of receiving unsafe care. Staff said they undertook hourly checks to ensure people in their rooms were safe and throughout the inspection staff were regularly checking on people in their rooms. However records of these checks were completed retrospectively and were not an accurate account of the checks undertaken.

Before the second day of our inspection we had requested documents we would need to look at on our return regarding the safe running of the service. These records were not promptly accessible when requested and some could not be found.

The provider was not ensuring accurate records were kept in relation to people at the home. This is a breach of

Requires Improvement

Is the service well-led?

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance** **The provider was not ensuring people were protected by having systems and processes to effectively ensure the safe management of the service. Because of quality assurance assessment and monitoring to improve the service had not been effective to identify risks.** **The provider did not seek feedback from people who use the service to continually evaluate and improve the service.** **Accurate records were not maintained in relation to people at the home and managing the regulated activity.** **Regulation 17 (1)(2)(a)(b)(c)(d)(e)**

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 **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing** **The provider was not ensuring staff were receiving appropriate support, training and professional development, supervision and appraisal.** **Regulation 18 (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The provider was not acting in accordance with The Mental Capacity Act 2005. People rights were not protected by appropriate assessment of capacity being undertaken, appropriate consent was not being gained to provide care and treatment and best interest decisions were not being made in accordance with this act. Regulation 11(1)(3)
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 Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care. The provider was not ensuring care and treatment was appropriate to meet people's needs. Because assessment and reviews were not being made and care plans did not reflect people's needs. The provider was not ensuring people were being able to participate in making decisions regarding their care or treatment. Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(d)(f)