Barchester Healthcare Homes Limited

Ashcombe

Inspection report

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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 19 and 28 May 2015 and was unannounced.

Ashcombe is a care home in Basingstoke that provides nursing and residential care for up to 33 older people who have a range of needs, including those living with dementia. It also provides nursing and residential care for people on short term stays for respite and post-operative care. At the time of the inspection there were 32 people using the service.

There was no registered manager at this location. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An interim manager had been brought to the service by the provider six weeks before the inspection to provide direction and leadership however they were not in the process of becoming registered at the time of the inspection. The provider was supporting the interim manager in their position with the aim of assessing their suitability to become registered with CQC.

Summary of findings

People using the service told us that they felt safe. Safeguarding training was delivered annually and care staff were able to identify and recognise signs of abuse. Procedures were in place identifying how people could raise concerns and staff were aware of these.

People told whilst they felt safe they were having to wait long times to receive assistance. Call bell audits showed that there were not always enough suitably deployed care staff to meet people's needs in a timely fashion.

Care staff were knowledgeable about the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments were undertaken for people who lacked capacity to make specific decisions. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

When risks were identified people were supported to remain safe. Care staff were able to recognise when people were at risk and change their care accordingly to meet any additional needs.

Thorough staff recruitment procedures were in place so that people were protected from the employment of unsuitable staff. Induction training was mandatory to ensure care staff were prepared for their roles

Nurses responsible for supporting people with their medicines had received additional training to ensure people's medicines were being administered, stored and disposed of correctly.

People were supported to eat and drink enough to maintain a balanced diet. People at risk of malnutrition and dehydration were assessed to ensure their needs were met. However records for people who required food and fluid chart monitoring were not always completed fully. As a result it could not always be identified whether people were eating and drinking sufficiently to maintain their health. People told us that the food was of a high standard and in more than sufficient quantities.

When changes were identified in people's healthcare the manager engaged with other healthcare agencies and professionals to maintain people's safety and welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Care staff sought consent before carrying out care, treatment and support. Appropriate applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted.

People told us that their care was provided to a good standard. Care staff demonstrated that they had taken the time to know the people they supported. People were encouraged and supported by care staff to make choices about their care on a daily basis.

People told us and we could see that all staff treated people with respect and their dignity was respected at all times.

Care plans were personalised to each individual and contained detailed information to assist care staff to provide care in a manner that respected that person's individual needs and wishes. Relatives were involved at the care planning stage and during regular reviews

People knew how to complain and were happy to provide feedback if this was required. Procedures were in place for the provider to manage and respond to complaints in an effective way. People, relatives and care staff were encouraged to provide feedback on the quality of the service provided regular meetings with the care staff, manager and provider.

The provider operated a quality audit process however the results were not always actioned appropriately to drive improvements in the service. People's records did not always contain all of the required information for care staff to deliver consistent care to meet people's needs effectively and safely.

Not all care staff told us they felt supported by the new manager. However, care staff told us they felt supported by their colleagues and the deputy manager.

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

The service was not always safe.

People were safeguarding from the risk of abuse. Staff were trained to protect people from abuse and harm and knew how to report if they had any concerns.

There was a robust recruitment process in place to ensure suitable staff were recruited to the service.

Contingency plans were in place to cover unforeseen events such as a power loss or fire.

Medicines were safely stored and administered by nurses who had received appropriate training and regular assessments of their competence.

There were not always sufficient care staff to meet people's needs safely. People told us, and documentation showed, that people sometimes had to wait for over twelve minutes for support when requested.

Is the service effective?

Requires improvement

The service was not always effective.

Care staff knew the people they were supporting and the care they needed.

Care staff understood the principles of the Mental Capacity Act 2005 and were able to show an understanding of the Deprivation of Liberty Safeguards (DoLS)

People were supposed to be able to eat and drink sufficient amounts to meet their needs and were offered a choice of food that met their likes and preferences.

Care staff supported people to seek healthcare advice and support whenever required.

Is the service caring?

Good

People told us that care staff were caring. All staff were motivated to develop positive relationships with people showing an interest in their personal histories.

People were encouraged to participate in creating their care plans. When they did not want to engage relatives were involved with the provider in planning and documenting people's care allowing them to express their family members needs and preferences.

Care was given in a way that was respectful of people and their right to privacy whilst maintaining people's safety.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People's needs had been appropriately assessed. Staff reviewed risk assessments on a regular basis with additional reviews when people's needs changed.

People were encouraged to make choices about their care which included where and how they wished to spend their time at the service.

There were processes in place to enable people to raise any issues they had about the service.

Is the service well-led?

Requires improvement 

The service was not always well led.

The home promoted a culture which was focused on people's experiences and actively encouraged feedback from people and their relatives in order to continually improve

The manager and provider were visible in the home. People told us they would be able to approach them to raise concerns. However not all staff felt supported by the new manager care staff stated that although the manager listened to their concerns, they did not feel that they always acted to resolve them.

The provider did not always maintain an accurate and complete record in respect of people's care and treatment.

Quality audit systems were in place to identify potential risks to people leaving them at risk of harm. However comprehensive action was not always taken as a result of these audits to ensure risks were managed effectively.

Ashcombe

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

This inspection took place on the 19 and 28 May 2015 and was unannounced. The inspection was conducted by two inspectors and an Expert by Experience who spoke with people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of family who had received nursing care.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at the provider's website to identify their published values and details of the care they provided.

The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with seven people and four people's relatives, four members of care staff, the chef, two nurses, one maintenance person, activities co-ordinator, one visiting healthcare professional, the manager and regional director for the provider. We looked at six people's care plans, five staff recruitment and training programme files, three people's medication administration records (MARs), staff supervision and training records. We also looked at kitchen and maintenance records, care staff rotas for the dates from 4 May until the 24 May, quality assurance audits, policy and procedures and complaints. During the inspection we spent time observing staff interactions with people including a lunch time sitting and observed a staff training session.

Following the inspection we also spoke with another health care professional and a doctor from a visiting GP's practice.

The service was previously inspected on the 21 September 2013 and no concerns were raised.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Ashcombe House. Interactions between all staff and people were positive and people were relaxed. One person told us, “I feel safe, there is always someone around” and a relative said, “my mother is absolutely safe here, we looked at three places, I have no fears here, she is well looked after and clean”. Another relative told us, I do feel my parent is safe here, I would know what to do and who to contact if I felt she wasn’t safe”.

However there were not always sufficient numbers of care staff correctly deployed to meet people’s needs in a timely way. People told us they sometimes had to wait to receive requested support. One person told us when , “I press my bell, I have to wait when they are short of staff especially at weekends” and another person told us, “I have to wait a long time for someone to come when I press my call bell”. One relative told us, “there aren’t always enough staff”. During the inspection call bells from people requesting assistance were consistently ringing. We saw that on occasions during the inspection staff were taking over seven minutes to respond to call bells which meant people were not receiving assistance when required.

The provider determined overall staffing numbers using the Dependency Indications Care Equations (DICE) assessment tool. There was an annually conducted review of all people’s care plans and the provider used specific criteria to identify the correct number of staff who would have to be deployed to safely meet people’s needs. The manager said they were able to request additional staff from the provider if people’s needs changed and were able to evidence the necessity from the person’s care plan. No such requests had been made at the time of the inspection.

During the inspection it was seen there was not the right numbers of skilled and experienced care staff on the upper floor. This was where there were a number of people who required additional assistance with their daily care. Care staff were delivering safe care to each individual making sure their needs were met before assisting others however there were insufficient numbers to manage the number of requests for assistance that were being made. We could not see that anybody was coordinating care staff to where they were most required.

The manager and regional director told us they were currently deploying over and above the required number of six care staff in the morning, five care staff in the afternoon and two care staff working overnight but we could not see that people were having their needs met at the time they requested support. One person told us that they would have to wait for assistance to go to the toilet and as a result would have to wear incontience pads which they did not wish to do. This person was at risk of suffering falls as a result of trying to mobilise to go to the toilet without assistance and told us they had attempted to when their request had not been answered. The manager was made aware and agreed that there was not always the right mix of experienced staff deployed on the upper floor prioritising care staff to where they were most needed. On the second day of the inspection it was noticeable calmer on this floor as there was a more experienced care staff member available directing care staff. However call bells continued to ring when people requesting assistance were not being responded to by staff.

Call bell audits for a four day period demonstrated that people were having to wait to receve assistance after they had requested it. Records showed that over a quarter of these calls in this period had resulted in people waiting over five minutes before being attended. A further 12.5% of the 484 calls made had had to wait over 12 minutes before they received assistance.

The manager explained that on some occasions care staff were not always cancelling the call bell when the entered a person’s room. As a result this was showing that people were waiting excessively to receive a response when this was not necessary the case. However, people told us they

Requires improvement

Is the service safe?

were waiting what they felt was a long time to receive support when requested. On the first day of the inspection we noted that on one occasion three people were searching to find a wheelchair for one person whilst others were still requesting assistance.

Care staff told us that they were slow in delivering care due to having new care staff who were learning on the job, ”you can’t give quality care when you are short staffed and you have new staff”. One person told us, “they (care staff) never have time to sit and chat”. A relative also told us, “there aren’t always enough staff”.

The provider did not ensure that there were sufficient numbers of suitably completent, skilled and experienced staff deployed to meet people’s needs in order to keep them safe.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we informed the provider of these concerns they were able to evidence that they had identified the need for additional support at peak times and was in the process of recruiting extra care staff to address this. The provider was also in the process of recruiting an additional nurse to support care and nursing staff.

Robust recruitment procedures ensured people were supported by care staff with appropriate experience and suitable character. Care and nursing staff had undergone the required recruitment checks as part of their application and these were documented.

All staff spoken with were able to demonstrate their awareness of what actions and behaviours would constitute abuse. Staff were also knowledgeable about their responsibilities when reporting safeguarding concerns. The provider’s own policy provided guidance for all staff on how and where to raise a safeguarding alert. Staff received training in safeguarding vulnerable adults and were required to repeat this on an annual basis. People were being cared for by staff who knew how to recognise the signs of abuse and what action they should take.

There were robust contingency plans in place in the event of an untoward event such as loss of utilities or fire. In the event of an evacuation people would be moved, temporarily, to care homes nearby. These plans were detailed and ensured that the potential risk of harm was minimised whilst maintaining people’s continuity of safe care. Evacuation processes were also practised with all staff on a regular basis to ensure that in the event of an emergency they would know their roles and responsibilities.

Arrangements were in place for the safe storage, administration and disposal of medicines. Audits and nurse competency assessments ensured people’s medicines were administered safely. We observed safe medicine administration practice by the nurses, with medicine being provided at the prescribed times. There were systems in place to ensure that there accurate stock record details of medicines.

Requires improvement

Is the service effective?

Our findings

Most people we spoke with were positive about the care staff having the ability to meet their care needs. Care staff promoted people's ability to remain independent. One person told us, "the staff are very kind…they know what they are doing". Another person said, "they try to keep me independent and I try to comb my hair and things".

All the people we spoke with praised the food which was provided. One person and a relative told us, "the food in here is very good", another person told us the same including, "we have the vegetables that are in season". People were given choice regarding what they ate, if they didn't want what was on the menu this was accommodated. One person told us, "they would make me a different meal if I didn't like what was on offer".

We observed people enjoying their food at lunchtime and being given choice regarding their meal. The chef and care staff were very knowledgeable about who required a pureed, soft and normal diet. Snacks and drinks were readily available for people. In all rooms people had water and squash available however this was not always within reach when care workers were not available. This could lead to a risk of dehydration for those unable to mobilise and was brought to the manager's attention. During the second day of inspection we saw that people had drinks within their reach.

All staff received an effective induction into their role at Ashcombe. Care staff we spoke with confirmed they that they had received an induction and could have additional support before delivering personal care. One member of care staff told us that they had requested, and received, an additional week's shadowing to ensure their confidence before working. Shadowing is where new staff are partnered with an experienced member of care staff as they perform their job. This allows new care staff to see what is expected of them. As such care staff told us they felt supported by their colleagues. Care staff had undertaken training such as manual handling, health and safety and safeguarding vulnerable adults to enable them to conduct their role. Care staff we spoke with told us, "we are offered training all the time". New staff were provided with the guidance and information they needed to enable them to undertake their duties safely.

Staff responded effectively to ensure people's freedom was not unlawfully restricted without authorisation. The Care Quality Commission (CQC) monitors the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using the service be ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. There had been seven applications made at the time of our inspection. Records showed that these people had had a mental capacity assessment completed prior to the application of the DoL's. We found the provider had a good understanding of DoLS and was able to identify those persons who required an application in order protect their freedom and rights and used least restrictive options to support people appropriately.

People's views and decisions were respected. Care staff were knowledgeable about the requirements of the Mental capacity Act 2005 (MCA) and records showed people's mental capacity to make specific decisions had been assessed and documented. Care staff were able to illustrate the principles of the MCA and able to describe the times when a best interest decision may be appropriate.

Care staff received regular supervision and appraisals with the manager and senior staff. Supervision and appraisals are processes which offer support, assurances and learning to help staff development. Care staff told us, "we get annual appraisals, we have team meetings bi-monthly". The new manager had introduced monthly themed supervisions to ensure all staff were aware of developments in the different aspects of care. This process was in place so care staff received the most relevant up to date knowledge and support to enable them to conduct their role effectively.

However this process was not always effective. We noted that during the previous month care staff had received supervisions which included information regarding the correct completion of food and fluid charts. During the inspection the food and fluid charts viewed did not always reflect that this learning had been effective with incomplete entries for people's daily intake identified.

Requires improvement

Is the service effective?

People could access health care services when needed. People told us that they were able to see their own doctor and a doctor confirmed that they visited the location frequently. People had access to healthcare professionals when required.

Good

Is the service caring?

Our findings

People we spoke with told us, “the staff are caring and kind, they don’t rush me and they try to encourage me to stay independent”, and, “the carers are absolutely kind and compassionate, I visit every day”. A visiting GP also told us “staff are caring”.

Care staff were knowledgeable about people’s personal histories and preferences and were able to tell us about people’s interests and hobbies. Care staff took time speaking with people as they moved around thehome. People responded positively and were happy to talk with them. Care staff bent down to make eye contact when speaking with people to encourage meaningful interaction. During meal times the care staff who supported those to eat did so in a caring way. There were personal conversations about families and people were not rushed by staff when eating their meals.

People were treated with compassion and kindness when upset. During the afternoon a person who wanted to go home became distressed in the lounge. Two care staff approached this person and gently explained that they were at home. This person continued to be upset so care staff said they would take them to their ‘flat’ where their personal effects were. This calmed the person who was later seen sat in the upstairs lounge with some of their personal items. One relative told us, “they (care staff) quickly notice if mum looks cold and they get her a cardigan, they notice everything about her, she is not able to communicate”.

People were treated as individuals and encouraged to make choices about their care. This included how they wanted to spend their day, where they would like to sit to rest and eat as well as their choice of food. People were also able to choose what time they wanted to get up and go to bed in the evening. One person told us, “you can do what you like, I choose when I get up and got to bed, it is a good place to live, you can’t fault this place”. People were also provided with choice in a way that was easy for them to understand and respond to. One person in the living room was discussing what they had wanted to wear for the day and that they had been shown two outfits by the care worker which had helped them pick what they wanted.

People were actively encouraged by the provider to personalise their room and did so with pictures and personal items.

People were treated with respect and had their privacy maintained at all times. People told us care staff always knocked on their doors asking permission to enter and we saw that this was happening. Care staff were able to provide examples of how they respected people’s dignity. One member of care staff told us, “If I’m washing people I ask permission and leave their bottom half covered if I am doing their top half, and vice versa. I close doors, we have signs we hang on the door and them to notify when attention people.” Bedroom doors were always closed when personal care was being delivered and signs were hung over the door handle to prevent people entering. People were also respected by having their appearance maintained. People were well dressed, their hair was tidy and some of them had their nails painted in a way they liked. One person told us, “I feel listened to and respected”. A relative told us, “I am here quite regularly, I have never seen anyone being treated disrespectfully”. People felt respected and we saw that care staff knew and routinely practiced protecting people’s dignity.

Good

Is the service responsive?

Our findings

People we spoke with told us the care staff took the time to know who they were and addressed them as individuals. People's relatives confirmed that the care staff took the time to know people and learn about their interests. People who did not wish to engage in creating their care plans had relatives who contributed to the assessment and planning of the care provided. People who had been appointed Power of Attorney (POA) were consulted regularly about the delivery of care. A person who has been provided with power of attorney is there to make decisions for people when they are unable to do so for themselves. One relative told us, "I have POA for finance, health and wellbeing. They (the care staff) always contact me before they do anything. I am my parent's voice. They definitely listen to me and respect my views".

People's care needs had been fully assessed and documented before they moved into the home.This planning took into account people's history, hopes and concerns for the future as well what was important to them. For example people's spiritual needs were met by a local church who, every three weeks, would conduct Holy Communion for those who wished to be involved. All staff at the location had taken time to know the people they were assisting. We saw engaging conversation between people and the activities co-ordinators which displayed knowledge of people's personal preferences. The care plans gave care staff an understanding of the person they were caring for and how they could best meet their needs.

Although some people told us they were unaware what a care plan was. Their relatives confirmed that they had been the ones involved in creating the care plans and took part in the regular updates or when required. One relative told us, "mum's care is reviewed every six months", another said, "mum's care plan is reviewed often with me or my husband". One person told us that they were not involved in the planning which had upset them as their daughter had completed it all on their behalf. This was not a view which was shared by other people we spoke with. The manager said that some people did not wish to engage when completing their care plan preferring to leave the decisions to their relatives, however care staff would always try to involve the person.

The provider sought to engage people in meaningful activities. One person told us, "I don't have many interests or hobbies, I enjoy everything the activities coordinator arranges". There was one activities co-ordinator who was working within the home. One relative told us, "the activities manager is really good. She asks about what my parent would enjoy". An activities programme for a typical week was viewed which included cooking club, singing, music, board games and movie nights. There were also external trips available when the weather was appropriate. People were actively encouraged to go outside and take part in gardening activities to keep moving.

People's individual needs were regularly reviewed and plans provided accurate information for care staff to follow. Care staff told us they reviewed care plans on a monthly basis. This was done by means of a 'Resident of the Day' programme. On the day of the month which matched the person's room number they were chosen as Resident of the Day. On this date there was a structured and documented process which reviewed all aspects of their care. This included nutritional assessment, skin inspection, care plans review, Medication Administration Record (MAR) audit, room spring cleaned and a maintenance check of their room The manager used a 'Resident of the Day' form to make sure that regular monthly reviews of people's care plans and their needs were taking place. Records showed people's changing needs were promptly identified and kept under review. For example when people had a Urinary Tract Infection.

People were enabled to maintain their relationships with people who mattered to them. For example, one person receiving respite care was missing the company of her two friends whom

Good

Is the service responsive?

she regularly met with. As a result the activities co-ordinator regularly collected her friends to visit her enabling her to maintain her important relationships.

People told us they would be happy to make a complaint if they wanted to although not all knew how to do so. People were confident however that they would speak to care staff or the manager to address any concerns. One relative told us, “I have raised issues, I complained last year, everything has always been dealt with”. The provider kept a complaints folder and a recent complaint from was viewed. A relative had complained about a number of issues regarding her mother’s care. The previous registered manager had responded appropriately in a reasonable time scale with a detailed response of what action she had taken. This person’s complaint had been addressed, responded to appropriately and feedback provided to care staff as a result.

Requires improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. The previous registered manager left the location two months before the inspection. We found the provider was working towards improving the service since the previous manager had left. Additional management support had been made available to provide direction and leadership at the service. The new manager had been in post six weeks prior to the inspection and had not started the process to become registered. The manager in company with the provider were assessing their suitability for the role with the aim to become registered if appropriate.

A relative told us, “I think the problem with the location is a lack of stability at the top. My parent has been here for four years and had four different managers”. The regional director told us they wanted to create stability and support for people and staff them with support. The manager confirmed that they had been receiving support and guidance from a number of different qualified members of senior manager, this included having a mentor. Whilst there had been a number of changes in management a GP told us that “the “nursing staff have been quite stable”. This was confirmed by staff we spoke with who said that the deputy head and other colleagues were supportive of each other and they could openly seek assistance from experienced persons when required.

The provider had a set of written values for the service outlining the standards of care that was required of all staff. These were provided to all staff when they started working at the home. Additionally the registered manager told us that they wanted to instill a culture where care staff saw and treated people living at the location as, “Very Important People (VIPs)”. The manager had not yet had the opportunity to discuss these expectations with care staff. However through supervisions they were intending to reinforce these standards of care and values with care staff.

The provider and manager were keen to promote a culture at the home which focused on people’s experiences and sought information on how they could improve. People were involved in the running of the home and the provider valued their opinions. Staff, people and relatives were provided with opportunities to provide feedback on the quality of the service provided. Minutes from the last two ‘relatives and residents’ meetings showed people were actively encouraged to provide feedback on the quality of the service they were receiving. Feedback from these meetings was used by the provider to improve the experience for people living at the home For example a puzzle table and additional entertainment items were ordered in response to people’s feedback offering them more choice of how to enjoy their time at the home.

Relatives told us that communication between them and the manager was good and they were kept them informed when changes to care had been identified or requested. One person told us, “they phone and tell me if she is not eating properly”. Communication between all staff and people was positive, for example, people were being complimented on their appearance, encouraged to participate inactivates and comforted when distressed.

Staff had mixed views regarding the leadership of the new manager but acknowledged their lack of time in the position. A member of care staff told us, “the manager tells us what she wants and how she wants things to be, she is approachable, she does listen, but, I’m not sure she does anything”. Other care staff were positive about the new manager. One member of staff told us, “the new manager is very positive on the paperwork side, many carers are set in their old ways”. This person was able to provide evidence of how there had been a new change in the way care staff were being encouraged to complete care plans. It had been reiterated by the manager that these changes were for the benefit of people living at the home. Another member of staff said “the manager and I work together, we are open and honest, no

Requires improvement

Is the service well-led?

secrets…it's early days and people hate change". This showed that the manager was making steps to improve staff performance and the quality of the care.

The manager and regional director told us that care delivery systems were in place and constantly reviewed to ensure people received high quality care. They were focusing on improving staff consistency when implementing these systems which included daily record keeping. However we found that records were not always fully or accurately completed

A Quality First audit conducted on the 10 and 19 March 2015 noted that not all people's topical medication records had been fully completed by staff. Actions were identified as a result to ensure these were completed. However the same issue was also identified during a Medication Assessment Record (MAR) audit completed on the 15 April 2015. The documentation did not always show detailed instructions on how to apply the cream and when. This meant that when providing care for the first time care staff may not have always been aware of what was required in order to best meet that person's healthcare needs.

People who were assessed as at risk of malnutrition and dehydration did not have their fluid and food intake recrods accurately completed. Therefore it was unclear whether they had received sufficient amounts of food and drink. For example, one person's documented daily fluid intake target was up to one and a half litres of water a day. This was due to the person's risk assessment indicating that they were at 'high risk' of developing pressure ulcers. For one day, only 360ml of fluid had been recorded as being offered/ drunk. Another person was seen to have a number of half-drunk tumblers within their room and during the inspection these were removed and replaced with other full glasses. This person's fluid chart had not been updated to show how much that person had drunk during that morning. As a result the provider could not accurately monitor how much people who were at risk of malnutrition and dehydration were having to eat and drink.

The provider did not ensure that documentation relating to people's care was always an accurate and complete record in repect of the care and treatment provided.

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

The manager and regional director were already aware that some areas of documentation were not meeting the standards the provider expected of the location. However the new manager had been prioritising the actions to be taken in order to improve the quality of care for people since moving to the home which had included the recruitment new staff. The manager and provider were able to evidence between the two days of inspection that improvements in the completion of papaerwork were being made. The manager and regional director were able to proactively identify practices which were not yet working effectively, such as the monitoring of call bell audits and were taking steps to address these to improve the service for people living at the location. This meant that the manager and the provider were working together to mimise the risks and improve the quality of the service being provided to people.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014** **The provider did not ensure that complete and contemporaneous records were maintained in respect of each service user to ensure that risks were managed appropriately**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's needs.**