Aden House Limited

Aden Lodge Care Home

Inspection report

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Date of inspection visit: 23 November 2015
Date of publication: 17/03/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 23 November 2015 and it was an unannounced inspection. The service had last been inspected 29 July 2013 and was found to be meeting the regulations.

Aden Lodge provides care and support for 40 older people, some of whom are living with dementia. It is a purpose built home and provides single room accommodation with en-suite facilities. The home was divided into two units, one of which was used for people living with dementia. At the time of inspection there were 34 people using the service.

There was a registered manager in place. 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.

Training for staff in safeguarding was up to date and staff understood their roles and responsibilities in relation to keeping people safe. People who used the service told us they felt safe.

Summary of findings

Staff did not have a good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards. This mean people's human rights were at risk because the service had not taken steps to ensure staff understood their role in relation to depriving people of their liberty. However, staff did understand the need to ask for people's consent prior to carrying out any personal care.

Some of the care records we looked at were person centred and detailed but others were task orientated. Some of the care records had gaps in information recorded. This meant there was a risk some important information could be missed.

Medicines were administered by staff who had been trained to do so. People we spoke with told us they had their medicines on time.

Prior to this inspection we had received concerns about the number of staff working at the home. People who used the service told us they felt there were not enough staff and those that were on duty worked very hard. Staff we spoke with told us they felt there were not enough staff and had raised their concerns with the manager. During the inspection, we noted there were periods of time when one of the units had no staff to supervise people who were at risk of falls. The registered manager told us there were plans to increase the number of staff who worked at night but not during the day.

We saw interaction between staff and people who used the service was respectful and considerate. However, there were times when people's dignity was not being respected. People who used the service told us they thought the staff were very caring.

The registered manager carried out regular health and safety audits. This meant people were being protected against the risk of harm. The signage throughout the home was not very friendly for people living with dementia and there were plans in place to improve the environment.

We foundeight breaches of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the full report

The overall rating for this service is Inadequate and the service is therefore in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

Staff had received training in safeguarding and understood their responsibilities in raising concerns.

Medicines were administered by staff who had the training to do so.

Staffing levels on the unit for people living with dementia were low which meant people who used the service were not being supervised and were at risk of falls.

Staff worked hours in excess of their contract, sometimes working a whole twenty four hour period. This meant people were at risk of harm because they were being supported by staff who were working too many hours.

Is the service effective?

Inadequate

The service was not always effective

Staff did not have a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. This meant there was a risk people's rights were not being respected because staff did not understand their role and responsibilities in relation to people's ability to consent.

Training for staff was up to date which meant they had the skills to support and care for people.

People's weight was being monitored and referred to other professionals when there was a concern about weight loss.

Is the service caring?

Requires improvement

The service was not always caring.

People who used the service told us they felt the staff were very caring and they enjoyed living at the home.

We observed some good interaction between staff and people who used the service. Staff talked to people with respect and had a good understanding of people's need.

There were some instances when people's dignity was not always being protected and respected.

Is the service responsive?

Requires improvement

The service was not always responsive

Summary of findings

Care records reflected people's preferences. However, some people did not have a personal history in place. This could give staff a better understanding of the person, their personality and behaviour which would make care more person centred.

Care records were reviewed which took into account people's changing needs. This meant risk to people's health and well being was minimised because their support needs were being reviewed.

Although activities were planned, they were not always carried out. People who used the service told us there wasn't enough for them to do.

Is the service well-led?

Inadequate

The service was not always well led.

The registered manager did not always involve people who used the service in the development of the service.

Although staff felt supported by the manager, they felt the registered manager did not always listen to them and take their concerns seriously.

Relatives we spoke with felt the registered manager was approachable but was not always visible in the home when they visited.

Aden Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 November 2015 and was unannounced. The team was made up of three adult social care inspectors and a specialist adviser with experience in dementia and medicines.

Before the inspection, we would normally ask the provider to complete 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. However as this inspection was brought forward in response to concerns raised we did not ask for a PIR.

We spoke with 12 people who used the service, one relative and eight staff including seven care assistants, one senior staff member and the registered manager. We looked at seven care records and four staff files. We looked at audits carried out by the registered manager which included health and safety and fire safety files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We observed interaction between staff and people who used the service. We walked around the home and saw inside the bedrooms of four people who used the service.

Requires improvement

Is the service safe?

Our findings

Two of the people we spoke with told us, "I feel safe;" and, "I feel very secure." One of the visitors we spoke with felt their relative was safe living at the home.

All the staff we spoke with told us they had received training in safeguarding and had a good understanding of what might constitute abuse. They were able to tell us what they would do if they had any concerns about the safety and welfare of people who used the service. The registered manager had sent in notifications to CQC and alerts to the local authority which meant they had understood their responsibilities in relation to safeguarding. Although there was a safeguarding policy in place this had not been updated to include the addition of new behaviours which constituted abuse. The registered manager had not realised the policy was out of date and after checking with their other colleagues we were told by the registered manager all the policies were due to be updated by the end of 2015.

In the care records we looked at we saw risk assessments had been carried out in areas such as mobility, choking and skin integrity. One of the external health professionals we spoke with told us they felt staff followed their instructions such as repositioning people to minimise the risk of the development of pressure ulcers but they did not always record this on charts such as repositioning charts.

This demonstrates a breach of Regulation 17(2) (c) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The registered manager ensured people were kept safe through regular audits of fire safety equipment, electrical equipment and any equipment used when moving and handling people such as hoists. On the day of inspection, there was quite a lot of furniture lined up in the corridors. The furniture had come out of the lounge which was being redecorated. The registered manager told us there was no other space in the home where they could store the furniture. We saw people walked around the home without the furniture getting in the way.

The home was undergoing a significant amount of contractual work such as decorating in the home and building a fence outside the home. There were no risk assessments in place to identify and reduce the risk of harm as the works were carried out. We brought this to the attention of the registered manager. They did not tell us what they would do to address this. However, we did not feel the lack of risk assessment had an impact on the safety of people who used the service.

Prior to the inspection we had received concerns about poor staffing levels at the home. During our inspection, all the staff we spoke with told us they felt there were not enough staff on duty to provide care and support to people. They told us they did not feel the quality of care had been affected but it was a struggle to get their work done each day. They felt they had no time to socialise with people who used the service. They told us they had reported their concerns to the registered manager but felt they did not listen to them. Three of the people who used the service told us they felt there were not enough staff. One person told us, "They could do with some more staff, they work hard."

On the unit for people who lived with dementia there were two care staff present all the time with a senior care worker floating between the two floors. Many of the people on the unit required two staff members to support them with personal care and this meant people were left unobserved for long periods of time. During the inspection, we spent time on the unit for people living with dementia. We saw there were periods of time up to fifteen minutes when staff were not present in the lounge. One person on the unit had a history of falls. The accident forms for this person stated they should be continually monitored. However, with the two staff members supporting people away from the lounge there was an increased risk this person was not being supervised and was in danger of falling and sustaining an injury.

We spoke with a visiting health professional. They told us they felt there were not enough staff. They were concerned people who walked with purpose were not being supported or supervised mainly because staff had to double up to support other people in the home. However, they did not feel people who used the service were at risk because of the shortage of staff.

We spoke with the registered manager about the concerns raised by staff and people who used the service. They told us they felt there were enough staff and did not agree with what staff had told us and them. They did not accept there was an issue with staffing levels and showed us the dependency tool they used to determine staffing levels and

Requires improvement

Is the service safe?

allocation of staff to the different units each day. The dependency tool used by the home was under review. However, our observations showed there were insufficient staff to meet people's needs.

When we looked at the rota we saw three staff had worked in excess of 70 hours per week. We saw one member of staff had worked for 24 hours without a rest. We discussed our concerns with the registered manager. They told us they were aware of the excessive hours staff worked. They also told us staff had asked to work extra shifts and they had obliged. The number of hours care staff worked contradicted the policy of the service which followed the Working Time Directive 1998. This directive states each staff member is entitled to a 24 hour rest period every seven days. The rota we looked at showed staff worked in excess of this. This meant people who used the service were at risk of harm because staff worked for long periods of time without a break.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Staffing.

We observed the medicine round which was completed by a senior care worker. The senior care worker told us they had completed internal training on the safe management of medications. We saw they followed safe practice during the medicine round. The senior care worker was very patient with people when administering medicines and ensured people knew why the medicine had been prescribed. We asked the senior care worker what they would do if people refused to take their medicines. They told us they would record the refusal in the medication administration records (MAR). If people were persistent in their refusal to take medicines staff would discuss the situation with a pharmacist to see if medicines could be given in different way such as liquid instead of tablets and syrup instead of soluble.

We looked at the MAR charts for six people and saw they were in good order and followed current guidance on this topic. The senior care worker wore a red tabard during the medicine round. It clearly stated they were not to be disturbed during the medicine round. We asked them whether other care staff took notice of this and they said they were often interrupted during a medicine round. However, there were few medicine errors so in spite of the interruptions, medicines were administered safely. All medicines were kept in two medicine trolleys, one for each floor. The trolleys were stored in the locked treatment room when not in use.

Medicines were supplied in monthly blister packs for each person by a local pharmacy. The staff member administering the medicines told us people's medication was reviewed by the pharmacist, including the MAR charts. Any issues identified were discussed between the pharmacy, the home and the prescribing General Practitioner (GP).

Controlled drugs (CDs) were stored in a locked cupboard which was bolted to the wall of the treatment room. We checked the drugs stored in the CD cupboard with the recording book. The number of CDs in the drug cupboard correlated with the record book used by the service to record the administration of CDs. The register is audited on a weekly basis by the registered manager.

We saw some items had been stored in the CD cupboard and we asked the care staff to remove the items as the CD cupboard should not be used to store anything but controlled drugs.

The medicines fridge was at the right temperature and there was evidence that this was checked daily. All liquids and creams were stored appropriately in locked cupboards. However, the treatment room was very warm and the registered manager said that due to the work being carried out in the home over the past two weeks there was a problem with the temperature control in the treatment room. This had been reported. We were not sure how the re-decorating of the home could interfere with the temperature of the treatment room. It was not clear how long the temperature of the treatment room had been an issue or if this was to a level that might affect the efficacy of some of the medicines.

We noticed there was a problem with the water pressure in the bathrooms and in two of the bedrooms we looked at. The water pressure was very low and in one of the bathrooms there was no hot water flowing from the tap into the bath. The registered manager told us there had been a longstanding problem with the water pressure and attempts were on going to rectify the issue. This was confirmed by the maintenance person. The problems had not been resolved before the inspection had finished.

Requires improvement

Is the service safe?

This meant people were at risk of infection because there was no water for them to wash their hands in a temperature that was safe.

These are examples of a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at files for five members of staff. We saw the recruitment and selection process followed the policy of the provider and was robust. Each staff member had two references in place and the registered manager had ensured a Disclosure and Barring Service (DBS) check had been carried out. The DBS enables organisations make safer recruitment decisions by identifying potential candidates who may be unsuitable for certain work that involve adults.

There was a plentiful supply of gloves and aprons and we saw staff used them when supporting people with personal care. As we walked around the building, we noticed one of the bathrooms required cleaning. We brought this to the attention of the registered manager and they immediately asked a member of the domestic team to clean it.

Although there was some refurbishment work being carried out, the home was kept clean with no malodours.

Inadequate

Is the service effective?

Our findings

People who used the service enjoyed living at the home. One person told us, "The staff are lovely and they look after me." Another person told us, "Staff are very helpful."

The training matrix we looked at showed mandatory training in subjects such as safeguarding, moving and handling, MCA and DoLS and the Malnutrition Universal Screening Tool (MUST) was up to date for all care staff. The registered manager told us training in end of life and falls awareness was discretionary which meant staff did not have to do the training. Out of a total of 23 staff in a caring role, only nine had training in falls awareness. This was important because there were people who used the service who were at risk of numerous falls. None of the staff had training in stroke care and only four staff had training in diabetes. There were people living at the home that had diabetes or a stroke. This meant people who used the service were not always supported by staff with the necessary knowledge and skills because the provider had not made training mandatory for staff in specific areas of care. The health professional we spoke with told us, "I think the staff have the skills to do their job but not all the time."

New staff had a period of induction when they received training in specific subjects to enable them to perform their role effectively. Induction training included an introduction to dementia, and one staff member told us they felt this did not skill them up enough to really understand how to work with people living with dementia. However, dementia awareness was mandatory on the training matrix and the registered manager felt staff would learn as they gained experience and through the refresher training.

This examples demonstrate a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff we spoke with told us they received supervision and in the four staff files we looked at we saw staff had received a minimum of four supervisions during 2015. Supervisions had a set agenda and one staff member we spoke with told us, "Supervisions are good; you can get feedback on your performance." Staff confirmed they had annual appraisals where they identified their future developmental needs.

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

Although the training matrix showed training in MCA and DoLS was up to date, one staff member could not recall having had any training in MCA or DoLS and could not describe situations where people's liberty was being restricted. However, they did understand the importance of asking people for their consent to carry out personal care.

The unit for people living with dementia had a locked door with a coded keypad in place. Some people did not have the code to keypad and could not leave the unit. People who had been assessed as not having the mental capacity to make a decision to stay in the home should have DoLS applications in place as well as best interest decisions The registered manager told us six people had a DoLS in place and the registered manager had applied for a further six. In two of the four care records we looked at we saw a DoLS had been completed. In one care record a DoLS assessment had been carried out in 2012 with no outcome. The care record stated the assessment of DoLS should be reviewed monthly but we did not see any further assessment for a DoLS.

Although some people who used the service had the correct paperwork in place to support a DoLS application, this was not consistent throughout the home. The registered manager was aware care staff required further MCA and DoLS awareness training and training was being planned.

We asked the registered manager how many people who were living with dementia had undergone a capacity assessment under the MCA 2005. They told us they had not carried out any capacity assessments so were not aware how many people had capacity and how many required protection under DoLS. We found this information confusing in light of the applications that had been made. We found staff we spoke with did not have a clear understanding of their responsibilities in relation to capacity and consent to care but were under the

impression they followed the principles of the MCA 2005.However in two of the care records we looked at, where people had capacity, there was no evidence consent to care had been sought but in others we saw people had signed their consent to care. Other care records contained contradictory information in relation to consent and capacity. For example, in one care record we saw a capacity assessment had been carried out with the outcome the person lacked capacity, but the member of staff who carried out the assessment then answered all other questions which supported the person having capacity. Although capacity assessments had taken place, they were not being reviewed in line with the guidance on policy of the home which stated assessments should be reviewed monthly. We could not be sure people who lacked capacity had been assessed to establish whether they could make informed decisions such as whether they stayed in the home or consented to care.

These examples are a breach of Regulation 11 (1)(3)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Dietary requirements were identified through the admission assessment. In the care records we looked at we saw people's likes and dislikes had been identified and recorded. Staff monitored people's food and fluid intake daily and we saw people were weighed monthly with gains or losses recorded. Food and snacks were available throughout the day and people had cold drinks they could help themselves to. When there were concerns about loss of weight, the registered manager ensured referrals were made to the appropriate professional, the dietician for example.

People were offered a choice of hot and cold drinks prior to the lunchtime meal. The meal looked nutritious and well balanced. Although people who used the service told us they had been offered a choice of main meal at lunchtime, one person told us, "I don't choose [they] just plan it." When required, we saw staff sat beside people to assist them eat their meal. One person became distressed as they were having a drink, they were having difficulty swallowing their food and staff responded quickly to reduce their anxiety and minimise the risk of choking. Although this was not a regular occurrence there was a choking risk assessment plan in place for staff to refer to.

Although people enjoyed their food, as they sat next to each other there was no conversation between people who used the service or with staff. Conversation was difficult due to the layout of the dining room, where tables were set apart from each other and separated by a column. The registered manager told us they had plans to re-design the layout of the dining room to make it a friendlier environment for people to eat their meals.

One of the care staff we spoke with told us people were asked to choose from a menu the day before. For people living with dementia it would be difficult for them to remember what food they had ordered. The menus were not in pictorial form. For some people living with dementia, it is sometimes hard for them to recall what a certain type of meal looks like for example, spaghetti bolognese. It is easier for people to pick a meal when they can see what it looks like.

We recommend the provider refers to current guidance on this topic.

We saw people's health care needs were identified in their care records. The registered manager told us they had good relationships with local GP services and outside agencies such as physiotherapy, occupational therapy, chiropody, Community Psychiatric Nurses and district nurses.

Signage throughout the home was poor. On the first floor, two of the ceiling lights were not working making it difficult for people with limited vision to move around the floor safely. On the unit for people living with dementia, there were two small lounges people could access. The registered manager told us each lounge had been a bedroom with en-suite facilities previously as there had been no communal areas available for people to sit in. Although the two bedrooms had been converted into a lounge, the en-suite facilities were still being used. The registered manager told us they had raised concerns about the possibility of cross infection with the local authority, they had been told there was no problem with the facilities being in such close proximity to the lounge.

None of the radiators in the lounges were working and the window was open. It was a cold day and it felt cold in the each of the lounges people used. We raised our concern with the registered manager and they had reported the faulty radiators to the engineer. They could not tell us when they had reported the faulty radiators but the radiators did feel very cold to the touch. We checked to see whether there was a problem with the gas supply to the boiler and saw that safety checks had been carried out. Although the

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Is the service effective?

boiler was working and radiators in other parts of the building were working, we were concerned that the radiators had not been fixed even though the registered manager was aware of the issue.

These examples demonstrate a breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

One person who used the service told us, “The staff are very good.”

None of the people we spoke with were aware of their care record. Not all the care records we looked at had a personal history in place. Personal histories can help staff understand people more and enable care to be more person centred.

In the care records we looked at there was no evidence people had been involved in the preparation of their care record. One of the relatives we spoke with told us, “I have been invited to one care meeting in two years, they [care records] are supposed to be reviewed monthly but I haven’t been invited.”

We observed interaction between staff and people who used the service was warm and respectful. When people required support staff offered this discreetly. Training in dignity and equality was mandatory for all staff. The staff we spoke with demonstrated the importance of preserving people’s dignity and privacy. We saw staff knocked on people’s bedroom door and introduce themselves as they went in.

However, we saw people’s dignity was not always respected. For example, one person who had become distressed in the lounge was taken to their bedroom. The door to their bedroom was kept open and other people who used the service were going into their room as they were concerned at the person’s distress. We asked staff why the bedroom door was not closed and they told us they had concerns about the safety of the person. This meant the person was not being afforded any privacy.

In the dining room on the ground floor, we carried out a SOFI and we observed staff used a hoist to transfer a person from their wheelchair to a chair. As they were being hoisted their trousers fell down and staff did not make any attempts to adjust the person’s clothing.

During general observations we saw people looked well-kept with clean clothes; however some people had dirty finger nails.

We saw advance care records for two people. One contained information about supporting the person to die with dignity and without pain. However the other care record we looked at did not contain sufficient detail or actions for staff to follow, it simply stated, ‘To be decided at the time.’ None of the other care records we looked at had any end of life plans in place. As training in end of life care is not mandatory not all staff had any training or the skills and understanding how to support people at end of life. This meant people who used the service were at risk of not being able to have the care and support where they want it and not experience a dignified death. We discussed this with the registered manager and they felt staff should have training in end of life care but as it was not mandatory training would only be given when it was required within the home.

People could have visitors at any time of the day but there was no space for them to meet with visitors in a private room, apart from their bedroom. We observed one person had a conversation with a relative via skype and this took place in a public space. We asked the registered manager why the person was not offered the opportunity to talk to their relative in a more private arena. They told us the person did not object to using skype in a public space.

These examples are a breach of Regulation 10 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Dignity and Respect.

In one of the care records we looked at we saw the advocacy service had been involved to support the person in a specific situation. Advocacy services support people who are assessed as being vulnerable to be involved in decisions about their lives such as in an application to deprive people of their liberty. This meant the service took steps to protect people’s human rights.

As we looked around the building we saw people’s bedrooms had been personalised to reflect their taste. Some people had photographs of their relatives on the walls and others had ornaments on the window sills.

Requires improvement

Is the service responsive?

Our findings

The care records were not always completed correctly for example in the section about sexuality, it talked about clothes and hair care. We brought this to the attention of the registered manager, they told us they did not see a problem with what staff had written down. They felt the record detailed what was important to the person in this particular section of the care record.

We found some of the care records were task orientated and generic rather than person centred. Other care records were detailed and centred on the needs of the individual. One of the care records we looked at contained guidance for staff to follow when people had specific conditions.

The home carried out pre admission assessments; this ensured the service was able to meet the needs of the person. Once settled into the home, the person had another assessment of need and a care plan followed on from this assessment. The assessment covered areas such as how people communicated and how they preferred their personal care be carried out. Risk assessments were in place and detailed risk of; choking, malnutrition and falls. Care records had been reviewed on a monthly basis and amended to reflect any changes in people's health and well-being. This meant although people were receiving individualised care and support this was not always recorded in their care records a consistent way. Although care was not being recorded in a consistent way, we saw staff did respond to people in a way which showed they had a good understanding of their support needs.

Activities had not taken place within the home and when we asked one person who used the service what they did through the day they told us, "Well I just sit here and watch the cat." None of the people we spoke with told us they took part in any activities within the home. We discussed this with the registered manager, they told us they were in the process of recruiting an activities coordinator and they hoped this would address the lack of meaningful activities within the home. In the most recent quality questionnaire, of the two people who answered the question about the amount of activities taking place in the home one person was satisfied and one person felt there was room for improvement. We did not see any activities taking place during the inspection

This is evidence of a breach or Regulation 9 (1) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

During the SOFI we saw staff attended to people in a timely manner and responded to them with respect.

We looked at the complaints file and saw any complaints made had been dealt with in line with the policy and procedure of the provider. The number of complaints was small, just two. We spoke with the registered manager about the small number of complaints. They told us they would often try to resolve concerns before they reach the point where people wanted to complain. However, they do not log these concerns so it was difficult to establish whether there were any patterns or trends in the concerns being raised. The quality questionnaire carried out by the registered manager showed one person knew about the complaints procedure and one person did not know about the complaints procedure. None of the staff we spoke with had been given a questionnaire to share their views and experiences of the service.

Inadequate

Is the service well-led?

Our findings

One of the relatives we spoke with told us," [registered manager] is accessible and if [they] don't know [they] point you in the right direction."

Staff we spoke with felt supported by the registered manager and were able to share their concerns. However, they felt the registered manager did not always listen to their concerns, especially around staffing levels. The external health professional we spoke with also found talking to the registered manager difficult because they felt they did not always listen or take on board their concerns.

Staff had an understanding of the vision of the home. They felt the registered manager tried to ensure people who used the service got the best care and support. Although staff felt they could contribute to the developments within the home, not all the staff felt this way. One member of staff we spoke with felt they had not been involved in the way the home was being redecorated.

The registered manager had carried out a quality questionnaire with people who used the service. Two people out of forty had completed the form. The results showed on the whole, the two people were satisfied with the service they received. However, they also felt there was room for improvement. Following the inspection we contacted the registered manager whether the results of the survey did involve just two people but we did not receive a reply to our question. Some people who live with dementia may have difficulty filling out questionnaires, such as the ones used by the home. However, we did not see any other form of communication used to seek the views about the home from people living with dementia.

Although there was an agenda for a staff meeting dated 15 July 2015, there were no minutes for this meeting. The most recent minutes we looked at were for the 16 November 2015. In this staff meeting the agenda covered staff morale, dementia training and staff involvement. The registered manager told us a managers meeting had taken place on 8 October 2015 and the week beginning 16 November 2015. We saw minutes of another two meetings held in April 2015 for staff to discuss their concerns. This showed staff were offered the opportunity to share their concerns as a team. Staff we spoke with felt the meetings were also a good place to get some positive feedback from the registered manager.

The registered manager told us. "I love my job; I love the difference I can make." They told us they had worked their way up through the organisation to their current role of registered manager. They felt the provider offered opportunities for people to develop their skills and move into more senior positions. They had a clear understanding of their responsibilities and felt able to contact other managers within the organisation for support.

We discussed the concerns which had been raised prior to the inspection regarding poor staffing levels and the impact on the care people who used the service received. The registered manager told us they did not agree with the concerns and felt the staffing levels were not an issue. However, they were in the process of recruiting more staff in response to the concerns raised. We also discussed the issue of staff working excessive hours and they did agree staff were working longer and more hours than they should and they would look at how this could be addressed.

The registered manager ensured regular audits in health and safety had been carried out, including fire safety checks and there were personal evacuation plans in place for people.

The registered manager acknowledged record keeping was an area of concern. The registered manager told us they had been made aware of poor records keeping as an issue when it had emerged as a safeguarding referral. They told us they and had taken steps to resolve the problem with poor record keeping through training and closer monitoring.

The registered manager also acknowledged staff needed to keep themselves up to date with their training and felt training in Mental Capacity Act and DoLS should be better understood. With this in mine, training in wound care and MCA and DoLS was being arranged.

We saw incidents and accidents had been recorded. The documentation for recording accidents was not being used appropriately, for example, two falls had been recorded on the same record. Although the number and nature of accidents and incidents had been recorded, we could see no evidence how the registered manager analysed the information to establish any patterns or trends. One accident record stated the outcome as '[person] needs constant supervision' to minimise the risk of falls. However,

Inadequate

Is the service well-led?

this information was not recorded in their care plan. When we talked to the registered manager about this they had not seen the information staff had written down on the accident report.

This meant people were at risk of harm because the registered manager was not reviewing the accident records to establish trends or patterns and put plans in place to minimise risk.

The registered manager told us people who used the service had been consulted about the re-decorating of the lounge. There was no evidence to support what they had told us and staff we spoke with confirmed no meetings had taken place with people who used the service to ask their opinion of how the lounge should be decorated. The provider's policy of involvement stated it was the responsibility of the manager to hold a relative and residents meeting every eight to twelve weeks. No meetings had taken place on such a regular basis. We asked the registered manager to send us documentation showing any residents meetings that had been held, they have sent us blank documents of invitations to meetings and conversations with people who used the service. One of the relatives we spoke with told us they had never been invited to any meetings in the home. This showed the registered manager was not involving people in the development of their home.

None of the staff we spoke with had been given a questionnaire asking them to share their views and experiences of the service.

We looked at the complaints file and saw any complaints made had been dealt with in line with the policy and procedure of the service. The number of complaints was small, just two for 2015. We spoke with the registered manager about the small number of complaints. They told us they would often try to resolve complaints before they reached the point where people wanted to complain. However, they did not log these concerns so it was difficult to establish whether there were any patterns or trends in the concerns being raised. The quality questionnaire carried out by the registered manager showed one person knew about the complaints procedure and one person did not know.

Throughout the inspection we saw a number of concerns; Care records were not being completed consistently and recording of care carried out was not consistent. The radiators in the lounges on the dementia unit were not working and the registered manager was unable to tell us when they would fixed. Although accidents and incidents were being recorded, these were not being done in a systematic way. We could not see any evidence the registered manager was analysing the accidents and incidents to identify trends and put in place plans to reduce the number and frequency of falls. There were no robust governance systems in place for the registered manager to maintain an overview of how effective the service was in delivering care, support and treatment to people who used the service.

These examples demonstrate a breach of Regulation 17 (a) (b) (c) (f) 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Activities were not taking place so care and treatment did not meet the needs of the service user and did not reflect their preferences in relation to social activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who use services were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The service did not always seek consent to provide care and treatment from people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service were at risk because the provider had not taken steps to prevent the spread of infection.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The service did not always seek consent to provide care and treatment from people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Equipment in the home was not being properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager did seek or act on the views of people who used the service. The registered manager was not assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not always receive the training and professional development to enable them to carry out their duties.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There not always sufficient numbers of staff to meet the needs of people who used the service.