Mr & Mrs R G Williamson

Ashbourne House - Torquay

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 27 and 29 September 2016.

Ashbourne House – Torquay is a residential care home for older people. It is registered to accommodate a maximum of 28 people. On the days of our inspection there were 21 people living at the service. The service provides care and support for people living with dementia. The service also offers a day care facility.

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.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The provider managed the service and was registered with the Care Quality Commission. 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.

Prior to our inspection the Commission had been advised by the local authority that two safeguarding alerts had been raised. Concerns related to staffing levels, people not always being kept safe from avoidable harm or abuse, the training and competence of staff, and the management and leadership of the service.

People and their relatives told us there were not enough staff to meet their needs. Staff told us they felt pressurised and explained they were struggling to meet people's personal care and social care needs. The provider and manager recognised more staff were needed and were taking action, but had faced a delay in obtaining employment checks for some people. At the end of our inspection on day one, the provider was reviewing their day time staffing levels and had increased their staffing levels at night.

People received care from staff who had undergone training to meet their needs. However, essential training, such as dementia care had not been undertaken by staff, but the provider told us this had been booked for October 2016. Staff were not supported and supervised to ensure people's needs were met effectively. Staff told us they did not feel supported by the manager or provider, telling us they did not feel they listened to their concerns about the current staffing pressures they faced and the impact that this was having.

People told us staff were kind. Staff, interacted with people in a kind way but were observed to be rushed in their approach, and predominately focused on tasks. People's friends and relatives could visit at any time and were made to feel welcome. People's privacy was respected.

People's dignity was not always promoted. People appeared unkempt. Relatives commented that sometimes their loved one was found to be wearing other people's clothes, and that their clothing had not been changed for a number of days.
People were not protected from risks associated with their care. People did not always have risk assessments in place, and staff did not know how to meet people's moving and handling needs safely. Risks associated with people's nutrition and hydration, were not being effectively monitored to help ensure prompt action was taken when necessary. Risks associated with people's skin were not being managed to help reduce the likelihood of people developing pressure sores. Accident reports and records were not always legible or detailed. This meant the provider was unable to effectively investigate incidents, to be able to put plans for improvement into place.

The provider had environmental risk assessments in place to identify how risks should be managed to ensure people's safety. However, action had not been taken to address previous environmental concerns raised at our inspection in July 2014.

Moving and handling and fire equipment was serviced in line with manufacturers' guidelines, to ensure it was safe to be used. People had personal emergency evacuation plans (PEEPs) in place which meant emergency services could be informed of how people should be assisted in an emergency, such as in the event of a fire. Thermostatic valves ensured the water temperature was regulated so people did not burn themselves.

People were not protected from avoidable harm and abuse, because the provider did not learn from mistakes and staff did not fully understand safeguarding procedures. People were not always protected from infection control practices to help prevent and control the spread of infection. Infection controls audits had not helped to highlight when improvements were required.

People were supported with their medicines in a respectful manner; however people's care plans did not always provide details about their medicines. This meant staff may not know how people needed to be

supported. People's medicines were not always recorded accurately when administered which meant it was not clear if they had been given the correct dose. Monitoring checks did not always highlight where improvements were required. People had access to health care services to support them with their ongoing health and wellbeing.

People's human rights were not protected because the manager and provider had a limited understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Where decisions were being made for people, there was no evidence to show that a best interests process had taken place to ensure the least restrictive options were considered. People's consent to care was asked for prior to the person being supported, however people's care plans did not document their consent to the care and support they were receiving.

People enjoyed the meals provided, however, people and their loved ones had not been involved in the creation of the menu which meant people's likes and dislikes were not always being considered. People's nutritional care plans were not always up to date and reflective of the support they needed, which meant people may not be supported correctly. People's care plans did not always prompt staff to take responsive action to help ensure people were effectively supported with their nutrition and hydration, and to ensure that concerns were escalated to healthcare professionals when necessary.

Pre-assessments were carried out prior to a person moving into the service. However, the recent pre-assessments had failed to take into account the staffing pressures at the service and that staff had not undertaken dementia training. The admission of new people had therefore placed a further pressure on the service and had negatively impacted on the care and support people already living at the service received.

People did not receive personalised care which was responsive to their needs. People had care plans in place, but care plans were not up to date and reflective of the care they required. This meant staff did not have the correct information to provide safe, effective and responsive care to people.

Care plans which had been created by external healthcare professionals were not always followed to ensure people's needs were met. People, who were cared for at the end of their life did not have care plans in place. This meant staff did not have information about what people's wishes and preferences were to enable them to provide personalised care and support.

People's care plans had not been created with the person or their families to ensure they reflected their wishes and preferences. People, living with dementia did not have care plans to inform staff of the best way they should be supported. People had little to do through-out the day to occupy themselves. Social activities were limited.

People's complaints were not always effectively listened to and resolved, and complaints were not always used to improve the service. The provider and manager told us they would reflect on how they had handled previous complaints, in order to make improvements.
There was a management structure in place which included the provider and manager. However, the manager was unable to manage the service effectively because they had been working as a member of staff, due to staff shortages. Relatives, staff and some external health and social care professionals told us they did not feel the service was well-led; and the findings of our inspection also demonstrated the service did not have effective leadership.

The provider had some systems and processes in place to help monitor the quality of care people received. However, the tools which were in place had not identified areas requiring improvement and people's

feedback was not obtained to help develop the service in line with people's preferences.

The provider had failed to notify us of all significant events in line with their legal obligations. Records showed the provider had not learned from previous safeguarding alerts which had been raised and investigated. The provider did not act on feedback from health and social care professionals in order to improve the service for people.

The provider and manager were open and transparent during our inspection. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment. The provider and manager told us they wanted to work collaboratively with external health professionals in order to improve the quality of the service for people.

We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People and their relatives told us there were not enough staff to meet their needs.

People were not protected from risks associated with their care, because risk assessments were not always in place and used by staff to ensure people were kept safe.

People were not protected from avoidable harm and abuse because the provider did not learn from, and implement recommendations from safeguarding investigations.

People were not always protected from infection control practices to help prevent and control the spread of infection.

People's care plans did not always provide detail about their medicines, which meant staff may not know how people should be supported. Monitoring checks did not always highlight where improvements were required.

Is the service effective?

Requires Improvement

People received care from staff who had undergone training to meet their needs. However, essential training, such as dementia care had not been undertaken by staff. Staff were not effectively supervised to make sure they put their training into practice.

People's consent to care and support was not always sought. The Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS) were not implemented and understood by the manager, which meant people's human rights were not protected.

People enjoyed the meals provided. However, people's care plans did not always prompt staff to take responsive action to help ensure people were effectively supported with their nutrition and hydration.

People had access to health care service to support them with

their ongoing healthcare.

Is the service caring?

Requires Improvement

People were not actively involved in making decisions about their care and support.

People's dignity was not always promoted.

People, who were cared for at the end of their life did not have care plans in place. This meant staff did not have information about what people's wishes and preferences were.
People's privacy was respected.

People received care from staff who showed kindness.

Is the service responsive?

Inadequate

There was a focus on completing the tasks associated with people's care needs rather than supporting people as individuals.

People's care plans were not up to date and reflective of the care they required. This meant staff did not have the correct information to provide safe, effective and responsive care to people.

Care plans, created by external healthcare professionals, were not always followed to ensure people's needs were met.

People's opportunities for social activities were limited and people told us they had little to do to occupy themselves.

The provider had a complaints policy; however people's complaints were not always effectively listened to and resolved. Complaints were not always used to improve the service.

Is the service well-led?

Inadequate

Relatives, staff and some external health and social care professionals told us the service was not always well-led.

The manager was unable to manage the service effectively because they had been working as a member of staff, as there were not enough care staff.

The provider did not have effective systems and processes in place to help monitor the quality of care people received.

The provider did not always act on feedback from health and social care professionals in order to improve the service for people.

The provider had failed to notify us of all significant events in line with their legal obligations.

The provider told us they wanted to work in collaboration with external professionals to help improve the service.

Ashbourne House - Torquay

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.

We visited the care home unannounced on 27 and 29 September 2016. The inspection team consisted of one inspector.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We also contacted Healthwatch Devon and the local authority.

During our inspection we spoke with five people, observed how people spent their day, as well as people's lunch time experience. We also spoke with four relatives, four members of care staff, one domestic, the chef, a kitchen assistant, the manager and the registered providers. We also spoke with a social worker and district nurse.

We looked at ten records that related to the care and support of people, three medicine administration records (MARs), accident and incident records, staffing rotas, staffing dependency tools, the provider's training matrix, and five personnel files. We also looked at quality assurance and monitoring paperwork, complaints and

After our inspection because of identified concerns we raised a safeguarding alert with the local authority. We also contacted a GP practice and district nurse to obtain their views about the service.

Inadequate

Our findings

People, relatives and staff told us there were not enough staff to meet their needs. We observed staff were focused on completing tasks and were unable to spend time with people. This meant people spent the day sitting in the lounge with the TV on, and had limited social interaction.

Relatives praised staff and described them as "marvellous" but told us, there were not enough of them. One relative told us they had already met with the provider to raise concerns about staffing levels, particularly about staffing arrangements at the weekends.

There was not enough staff to meet people's needs. Staff told us they were struggling to meet people's basic personal care needs, such as helping people to get washed and dressed because of a shortage of staff. Staff told us eight people required the support of two members of staff, which meant one member of staff was left responsible for thirteen people. Staff told us this was unsafe, that morale was low and they felt pressurised.

The provider did not have an effective staffing tool to ascertain whether they had enough staff on each shift, to be able to meet people's individual needs. The provider's rota showed for twenty one people, there were seven care staff and two night staff employed. This meant the provider did not have enough staff employed to meet people's needs over a twenty four hour period, seven days per week. The provider and manager explained agency staff were used to supplement staffing levels.

The provider and manager recognised they needed more staff and explained they were in the process of recruiting, but delays in employment checks, such as Disclosure and Barring Service (DBS) checks were taking time to be returned. DBS checks are necessary to ensure staff employed are safe to work with vulnerable people.

Night staffing levels were unsafe. There was one waking night staff and one sleeping member of night staff on shift for twenty one people. A member of night staff described a moving and handling technique they used, so as not to wake up their colleague. The moving and handling description was unsafe and placed people and the member of staff at risk of sustaining an injury. At the end of our first day of inspection the provider took immediate action to increase their night staffing levels.

The arrangements for staffing did not always ensure people's needs were met. There were not enough staff employed to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014

People were not protected from avoidable harm and abuse that may breach their human rights because the provider did not learn from mistakes. For example, safeguarding investigations had concluded documentation in respect of people's care was not always being completed. During our inspection we looked to see if this had improved and found that for two people, records relating to their personal care and nutrition had not been completed accurately or consistently.

Staff had received training in relation to safeguarding; however when asked what action they would take if they were concerned someone was being abused, mistreated or neglected, staff were unable to tell us what external agencies they could contact. This meant there was a risk that concerns about people may not be escalated.

People were not effectively prevented from abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not protected from risks associated with their care. People's moving and handling needs had not always been risk assessed or detailed within their care plans. This meant staff did not have guidance and direction about how people should be supported to keep them safe. For example, we observed one person was assisted with two different types of moving and handling equipment. However, their relative explained they had not seen one type of moving and handling equipment being used before, so they were concerned that staff had been taking an inconsistent approach. A member of staff also told us the person did not use one piece of equipment because they had not been assessed for it. We reviewed this person's care plan but it did not detail what equipment should be used.

Risks associated with people's nutrition and hydration, were not being effectively monitored to help ensure prompt action was taken when necessary. For example, it detailed in one person's care plan that they needed to be weighed on a monthly basis. However, this had not been carried out; their records showed a gap from 28 January 2016 to 6 September 2016 when their weight had not been monitored. This person's care plan also detailed the importance of monitoring how much they ate and drank, but records showed gaps when the person had not been offered anything to eat or drink. We spoke with the manager about this, who told us staff had been requested to complete the records accurately when the person was supported. This meant we could not determine if the person was having enough to eat and drink.

Risks associated with people's skin were not being managed to help reduce the likelihood of people developing pressure sores. For example, when a person needed to be re-positioned in their bed, their care plan did not give clear guidance and direction to staff about what to do and when to do it. Re-positioning charts were also not being completed accurately and in line with external healthcare guidance. For example, for one person district nursing staff had requested the person was to be re-positioned every two hours. However, records showed gaps of over three hours and we found the person's heals were not in the correct position as requested by district nursing staff. We spoke with the manager and provider about this, who took immediate action to address this with the staff team and we found an improvement to record keeping on the second day of our inspection.

Accident reports and records were not always legible or detailed. For example, one person had recently slipped off their bed and had sustained a fracture. However, the person's daily records and accident report were not clear about how this had occurred and what action had been taken. This meant the provider was unable to effectively investigate the incident and put into place effective plans for improvement. One person had a bruise on their hand. The person was unable to recall how this had occurred and the person's

care records did not provide details, for example there was no body map in place. We spoke with a member of staff and the provider about this; they told us the bruising had not been noticed.

The provider did not take responsive action in order to keep people safe. People's risks associated with their care had not always been assessed and documented to help staff know how to mitigate risks associated with people's care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not always provide details about their medicines, which meant staff may not know how people needed to be supported. For example, people who required support to apply prescription creams did not have records in place, to show where and when the cream was to be applied. We were told by a relative they had been concerned that their loved one had not been having their pain relief cream applied. We looked at this person's cream plan and could not find any information relating to this. We spoke with the manager about this, who explained the reason the cream was required and for what area, however could not confirm if it had been applied by staff. However, we saw from the person's care records the cream had not always been applied as described.

People's medicines were not always recorded accurately when administered which meant it was not clear if they had been given the correct dose. For example, one person took a blood thinning medicine, however the recording of the medicine on the person's medicine administration records (MARs) did not clearly show how much they had been given. The person did not have a care plan or risk assessment in place relating to the risks and complexities of taking such a medicine, such as how often they needed to have a blood test. The manager told us she would take action to rectify this.

Controlled medicines, used to support people at the end of their life, were not always recoded within the controlled drug book to ensure there was a record of stock. This meant, there was no record or audit trail to ensure these medicines were being safely stored and managed in line with National Institute of Clinical Excellence(NICE) guidelines. The temperature of the medicine fridge was not being recorded which did not ensure medicines were being stored at the correct temperature and in line with the prescribing guidelines, and the fridge was found to be unlocked.

Staff received medicine training, but their ongoing competency had not been assessed to ensure they continued to have the knowledge and skills to administer medicines. The manager had a monitoring tool to highlight where improvements were required; however the audit had not been effective in identifying when improvements were required.

People's medicines were not always stored safely. People did not always have accurate records and information in place relating to their medicines. Monitoring systems were not effective. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with their medicines in a respectful manner and medicine administration records (MARs) were completed after the person had taken their medicines. This was in line with National Institute of Clinical Excellence (NICE) guidelines. People were always asked if they would like their prescribed 'as required' medicine (PRN), such as paracetamol. People prescribed anti-biotics started these promptly.

People were at risk from infection control practices. Staff had received infection control training but did not always carry out correct practices. For example, personal protective equipment (PPE) was not always available or worn when entering the kitchen.

People's soiled laundry was not always handled in line with infection control guidelines. Staff told us soiled laundry was placed into water-soluble bags. However, the bags had not been dissolving so laundry was being removed from the water-soluble bags and placed directly into the washing machine. This meant there was a risk of cross infection. The provider and manager explained staff had not made them aware of this to enable them to take action.

A cleaner and laundress was employed for five days per week, outside of these hours staff carried out these tasks. However, staff told us they found it difficult to dedicate time because they were very busy. This meant in the absence of a cleaner and laundress the service was not cleaned and people's laundry had to wait to be washed.

The kitchen had been awarded three out of five stars from the Environmental Health (EH). We asked the chef the reason for this, but he was unable to tell us why because he could not remember. Kitchen paperwork was disorganised and there were no clear records to show the frequency of cleaning. The provider had an infection control policy and carried out audits to check staff's practice. However, the audits had failed to identify areas requiring improvement.

People were not protected by infection control practices. The staff and provider did not have up to date knowledge in respect of infection control practices. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had environmental risk assessments in place to identify how environmental risks should be managed to ensure people's safety. However, at our previous inspection in July 2014 we had told the provider that the arms of some chairs were ripped and the carpet in one area was a trip hazard, but action had not been taken to address this. We also found another rip in the lounge carpet which had not been addressed. The provider explained that they knew about the rip, and had been speaking with a carpet company but had faced difficulties in replacing it because of where the join of the carpet was.

Moving and handling and fire equipment was serviced in line with manufactures guidelines, to ensure it was safe to be used. People had personal emergency evacuation plans (PEEPs) in place which meant emergency services could be informed of how people should be assisted in an emergency, such as in the event of a fire. Thermostatic valves ensured the water temperature was regulated so that people did not burn themselves.

Requires Improvement

Our findings

Staff were not always supervised to ensure people's needs were met effectively. We observed, there was an inconsistent approach to how staff supported one person with their mobility, and people's care records were not always being completed accurately by staff. Records showed supervision of staff's practice had been undertaken, but the frequency of this could not be determined because there were gaps in records. The inconsistent staff practice demonstrated staff supervision was not effective in identifying poor practices.

New staff joining the organisation received an induction which introduced them to policies and procedures and to the ethos of the service. The care certificate was in place for people who did not have any experience of the care sector. The care certificate is a national induction training programme, to ensure staff work to the desired standards expected within the health and social care sector.

People received care from staff who had undergone training to meet their needs. However, essential training, such as dementia care had not been undertaken by staff, but the provider told us this had been booked for October 2016. The local authority service improvement team also advised the provider of training opportunities which were available locally, which assisted the provider to be able to stay in touch with local practice methodologies, such as safeguarding protocols.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

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

The manager and provider had a limited understanding of their responsibilities in relation to the MCA and associated Deprivation of Liberty Safeguards (DoLS), and although some DoLS applications to the supervisory body had been made when necessary, the manager and provider were not aware if any of the applications had been approved.

Some people's care plans recorded their mental capacity, however some did not. Where decisions were being made for people, there was no evidence to show that a best interests process had taken place to ensure the least restrictive options were considered. For example, one person smoked but their cigarettes were held by the provider. The provider and manager told us the person had agreed to this, however there was no information in the person's care plan to confirm they had given their consent.

People's consent to care was asked for prior to the person being supported, however people's care plans did not document their consent to the care and support they were receiving.

There was a limited understanding by the provider and manager of the legislative frameworks. Decisions were made for people without taking into consideration the Mental Capacity Act 2005 (MCA). This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not always prompt staff to take responsive action to help ensure people were effectively supported with their nutrition and hydration. For example, when people required their weight and nutrition to be monitored, this was not always done. One person's care plan detailed they needed to be weighed on a monthly basis and supported with their hydration on a daily basis. However, this person had not been supported in line with their care plan; records showed gaps when their weight had not been obtained and food and fluid charts had not been completed to show how much the person had drunk in one day.

People and their loved ones had not been asked to contribute to the creation of the menu which meant people's likes and dislikes were not always being considered. People's individual communication needs were not considered when they were asked what they would like to eat, for example the provider's pictorial menus were not used to help people make an informed choice. Staff told us this was because they did not have time. Staff told us, people sometimes received their lunch late because of staffing pressures.

People's nutritional needs were not always met in line with their needs, wishes and preferences. People's care plans were not always reflective of how their nutritional needs should be met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People enjoyed the meals provided. The dining room was set up with table cloths, mats and condiments; this helped people with memory loss to recognise the time of day. There was a pictorial menu displayed to take into consideration people's individual communication needs.

People had access to health care services to support them with their ongoing health and wellbeing. People's care plans showed GPs, district nurses, speech and language therapists (SALT) and podiatrists had been contacted for people, when required.

Requires Improvement

Our findings

People's dignity was not always promoted. People looked unkempt, for example some people had an odour of urine and dirt under their finger nails and some women had facial hair. People were unable to express if this was their choice, and their care plans did not provide us with details. We looked at the personal care records for the two people who had an odour of urine. Records detailed they had had one bath in August 2016 and two baths during September 2016. Staff explained they were struggling to meet people's personal care needs because of staffing difficulties.

A relative told us of an occasion when they had found their loved one looking unkempt with food down the front of their clothes. They told us how distressed this had made them feel, and that they had complained to the provider and manager, but it had since occurred again. Other relatives commented that sometimes their loved one was found to be wearing other people's clothes, and that their clothing had not been changed for a number of days.

People were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not actively involved in making decisions about their care and support. People were not consulted about where they would prefer to see their GP or district nurse. We were told by a district nurse that staff brought people into the manager's office to be seen, rather than asking the person what they would prefer. People's care plans did not show their involvement and a relative told us they had not seen or been asked to be involved in their loved one's care plan.

People, who were being cared for at the end of their life did not have care plans in place. The provider told us there were three people who were nearing the end of their life, so without care plans this meant staff did not have information about what people's wishes and preferences were to enable them to provide personalised care and support.

People were not involved in making decisions about their care and support. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were kind. One comment included, "The care staff are fabulous, I do believe they do give really good care. I think they do go over and above". Some people had taken time to write to express their thanks, comments included, "Thank you for the kindness you have shown", "Many thanks for looking after

me so well" and "We are very happy with the care that (…) is receiving".

Staff interacted with people in a kind way but were observed to be rushed in their approach. For example, not having time to stop and have a meaningful conversation. Staff spoke fondly of the people they cared for, but told us they found it difficult to be able to spend quality time with them, because they did not have time.

People's friends and relatives could visit at any time, and relatives told us they were made to feel welcome and always offered a cup of tea.

People's privacy was respected. People's individual care needs were discussed in private and people's bedroom doors were closed when they were being supported with personal care.

Inadequate

Our findings

Pre-assessments were carried out prior to a person moving into the service. Pre-assessments are essential in determining whether a service can meet the needs of a person prior to them moving into a service. However, the recent pre-assessments had failed to take into account the staffing pressures at the service and that staff had not undertaken dementia training. The admission of new people had therefore placed a further pressure on the service and had negatively impacted on the care and support of other people. For example, people were not being effectively supported with their personal care and their social needs were not being met.

People did not receive personalised care which was responsive to their needs. For example, one person commented to the provider at approximately 10am that they had a sore leg. When we spoke with the senior member of staff on duty later that day at approximately 3.30pm, they had not been informed of it. This meant the person had not been offered any pain relief and action had not been taken to establish whether the person needed to be seen by a GP or district nurse. The manager and provider told us this was not acceptable.

People had care plans in place, but care plans were not up to date and reflective of the care they required. This meant staff did not have the correct information to provide effective and responsive care to people. For example, one person was seen to walk with a walking frame but their care plan stated that they should be walking with a different type of equipment.

Care plans, created by external healthcare professionals were not always followed to ensure people's needs were met. For example, one person's care plan detailed they should be checked every hour to make sure they did not need any support with continence care and that they were positioned correctly in bed. However, we observed this was not always carried out and there were gaps of over an hour in the person's care monitoring records.

People, living with dementia did not have care plans to inform staff of the best way they should be supported, when faced with confusion, anxiety or anger. We saw one person become agitated, the provider and manager reassured the person by offering them a cup of tea, which seemed to help reduce their anxieties. However, the person's care plan did not describe the action staff should take to help this person to remain calm. There were also no social care plans in place, to help ensure people lived meaningful lives.

We observed a task ordinated culture to meeting people's needs. Staff told us they recognised this, but

explained it was because of staffing difficulties and the pressures they were faced with on a daily basis. They told us they always tried to do the best they could.

People's care plans had not been created with the person or their families to ensure they reflected their wishes and preferences. The manager told us she spoke with relatives when changes were made, however this was not always documented. One relative was critical about the lack of information shared by care staff. The relative told us that staff did not always keep them informed about changes to their loved one's care when they visited.

People had little to do through-out the day to occupy themselves. Social activities were limited; on the first day of our inspection people spent the day sitting in chairs in the lounge, with the TV on in the background. One member of staff made a conscious effort to ask people if there was anything they would like to watch, however this was not met with enthusiasm. On the morning of the second day, people were able to join in with an exercise activity, but later returned to sitting for the rest of the day. One person played a game with another relative who had been visiting. The provider told us, in the summer people had enjoyed trips out and we saw pictures displayed around the service of this.

People's care plans did not meet their needs and were not reflective of their wishes and preferences. People's care plans were not always effectively reviewed to ensure they were reflective of the care being delivered. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy; however people's complaints were not always effectively listened to and resolved, and complaints were not always used to improve the service. We read one letter of complaint and found the content of the complaint matched our inspection findings. We asked the provider and manager what they had done to investigate the person's concerns as this had not been documented. They told us they had met with person to explain what action they would be taking and had apologised. We spoke with the relative who told us they felt their complaint had not been handled appropriately and that they had left feeling tearful and upset. The provider and manager told us they would reflect on how they could make improvements.

The complaints system was not effective in ensuring people's complaints were listened to, investigated and responded to. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Our findings

Relatives, staff and some external health and social care professionals told us the service was not well-led; and the findings of our inspection also demonstrated the service did not have effective leadership. They told us, the manager and provider had not always listened to advice from health and social care professionals and were not always seen to be visible within the service. Staff told us they felt unsupported and that they did not feel the provider and manager recognised the severity of the staffing issues, the pressures they faced and the impact on people.

During our inspection, both the provider and manager were visible within the service, but staff and relatives told us the provider and manager usually spent lengthy times in the office, and did not always provide effective supervision. The manager and provider were surprised people felt this way, and told us they always had an "open door" policy.

People's feedback was not obtained to help develop the service in line with people's preferences. Staff meetings were not carried out, because the provider told us attendance was poor, so they had decided the best way to communicate and share information with staff, was at the beginning of each shift. Relatives explained there were no formal meetings to share ideas or to discuss the service.

There was a management structure in place which included the provider and manager. However, the manager was unable to manage the service effectively because they had been working as a member of care staff, due to the staff shortages.
The provider explained they had recently employed a deputy manager who would be assisting with the management of the service, but had faced a delay in obtaining the person's employment checks.

The atmosphere within the service was to carry out tasks rather than to provide individualised care and support to people. The culture of the service was also reactive rather than proactive; the provider and manager had relied on other external professionals to identify where and when improvements were necessary, and because of this some people had experienced poor care.

The provider had some systems and processes in place to help monitor the quality of care people received. However, the tools which were in place had not identified areas requiring improvement. For example, the medicine and infection control audits had failed to show when action had been required.

Accidents and incidents were monitored, but the auditing tool did not effectively reduce the likelihood of re-

occurrence because people's information was collated collectively and not individually. This meant individual patterns and trends could not be established to help minimise associated risks.

Records showed the provider had not learned from previous safeguarding alerts which had been raised and investigated. For example, records were not always completed accurately to reflect the care being delivered or action taken. Responsive action in relation to people's healthcare was not always taken.

External health professionals also told us there had been delays in implementing initiatives and paperwork they had provided to assist the provider to make improvements, such as a new food and fluid chart and a mental capacity assessment tool.

The provider did not have effective systems and processes in place to ensure the ongoing monitoring and quality of the service. People's feedback was not obtained to improve and develop the service. The provider did not act on feedback from health and social care professionals in order to improve the service for people. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of all significant events in line with their legal obligations. For example there had been a delay in informing us about a person who had sustained a fracture and been admitted to hospital.

The provider had failed to notify us of all significant events in line with their legal obligations. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider and manager were open and transparent during our inspection. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to people's care and treatment.

The provider and manager were clear that they wanted to work collaboratively with external health professionals in order to improve the quality of the service for people; however the provider did not always ensure advice and guidance was listen to and put into practice effectively.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to notify the Commission without delay of all significant events in line with their legal obligations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service users 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 Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment of service users was not

always provided with the consent of the person.

Service users, who lacked capacity, did not always have their human rights protected in accordance with the Mental Capacity Act 20015 (MCA).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Service users were not protected from abuse because there were ineffective systems in place to implement safeguarding recommendations. There was a limited understanding from staff about safeguarding procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not effectively record, handle and respond to complaints.